Arab Adolescents' Attitudes Towards Mental Health in Kuwait

By

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DECLARATION

This work, or any part thereof, has no previously been presented in any form to the University or to any other body whether for the purposes of assessment, publication or any other purpose, unless otherwise indicated.

Other than the expressed acknowledgments, references and/or bibliographies cited in the work, I confirm that the intellectual content of the work is the result of my own efforts and of no other person.

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Date: October 25, 2018

Abstract

Aims and Rationale:

Individuals suffering from mental health difficulties and disorders experience stigma and discrimination in various areas of their lives. Mental illness stigma results in diminished self-esteem, increased risk of suicide, feelings of shame and a decrease in their desire to seek support from mental health professionals. This study aimed to assess changes in attitudes following a brief informative talk on mental health. Moreover, the study aimed to explore the attitudes and beliefs of Arab high school students in Kuwait towards people suffering from mental illness. The findings aim to broaden an understanding of the subject area within the Arab population in order to inform future approaches to decrease stigmatizing beliefs and increase more accepting attitudes and help-seeking behaviors.

Method:

A mixed-method approach was used to examine attitudes towards individuals suffering from mental disorders in 111 Arab high school students. Firstly, the quantitative part of the study explored changes in attitudes following an informative talk using a survey questionnaire. 105 Arab high school students took part in the study and were divided into two groups, one group received a talk on 'Myths and Facts' around mental illness while the second group received a talk on 'Education and Career' paths one could take in the field of psychology. The qualitative part of the study explored 6 Arab high school students' beliefs around mental illness as well as

their personal experiences in dealing with mental health difficulties and discrimination using semi-structured interviews.

Results:

The findings of the quantitative study demonstrated an overall increase in benevolence and an overall decrease in social restrictiveness following the talks. Students in the 'Myths and Facts' group displayed a significant improvement in social restrictiveness attitudes following their talk, the 'Education and Career' group did not show this improvement. Findings from the qualitative study represented a juxtaposition between participants' expressed positive and supportive views towards individuals with mental illness and their expectations of negative behaviors and attitudes from the public towards those suffering from mental health difficulties.

Conclusion:

The findings provide an understanding of existing beliefs around mental illness in the Arab youth which in turn provides mental health professionals with the required knowledge to tackle the issue of stigma within this specific population. Educational approaches offer adolescents insight on mental illness and positively impact their opinions and views towards people suffering from mental disorders. This is crucial in promoting more accepting attitudes and encouraging help-seeking behaviors.

Contents

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CHAPTER 1:

LITERATURE REVIEW

LITERATURE REVIEW

Literature Review Search Strategy

In order to identify relevant literature several electronic databases were used such as: PsychINFO, PsychARTICLES, PubMed, PsychBOOKS as well as search engines such as Google and Google Scholar. The following terms were used in searches: stigma, mental health stigma, mental illness stigma, stigma psychology, adolescence and stigma, stigma in the Arab population, culture and stigma. Full articles were reviewed and reference lists were examined for further relevant research.

Language and Mental Health within the Study

Throughout the study several different statements are used to discuss mental health. The language used to refer to mental health included statements such as: 'mental illness', 'mental health difficulties', 'mental disorders', and 'mental health issues'. During the execution of the research as well as the write up phase, the researcher alternated between the above statements in order to provide a balance between the medical model of mental health (mental disorders and mental illness) and the more humanistic approach of counselling psychology (mental health difficulties and mental health issues). While the researcher is inclined towards the humanistic approach both within practice and research, a consideration of the public's knowledge around mental health and their ability to understand the phenomenon drove the researcher to include more common and recognized language such as

'mental disorders' and 'mental illnesses'. Moreover, the majority of the literature on mental health stigma referred to stigma around mental illness and mental disorders. The implications of using such language are discussed further in the discussion phase.

Structure of the Literature Review

1) The introduction focuses on the presence of mental illness stigma and its negative impact on people suffering from mental disorders as well as the need to confront this issue.

2) The second part of the literature review aims to define and place stigma within the context of mental health. A differentiation between the concepts of self-stigma and public stigma will be highlighted. An emphasis will be placed on the negative impact of public stigma on individuals suffering from mental health disorders and difficulties. Common beliefs and attitudes towards people with mental illnesses will be discussed in relation to attribution theory – the attempt to interpret the cause of one's behavior based on their intentions and feelings.

3) The third part of the literature review addresses the presence of mental health stigma in adolescence. The purpose of this section is to critically evaluate previous studies and attempts to decrease stigma within the younger generation and highlight the importance of educating the youth. Whilst emphasis is placed on

attitudes and beliefs, their significant influence on behavior will be highlighted in connection to the theory of planned behavior.

4) The fourth part of the literature review investigates the presence of mental health stigma within the Arab population. The purpose of this section is to explore the impact of culture, religion and shared values on attitudes and behaviors towards mental health. Additionally, mental health services in Kuwait are investigated in order to gain further insight on existing gaps.

5) The fifth part aimed to highlight the relevance of the present study.

6) Finally, the last part of the literature review focused on the researcher's rationale for using a mixed method approach.

1.1 Introduction

Despite extensive efforts to improve public understanding of mental health in the field of Psychology, negative perceptions towards people suffering from mental health difficulties and disorders have been remarkably constant (Pescosolido, Martin, Long, Medina, Phelan & Link, 2010). The stigma of mental illness is mostly caused by the stereotypes of people with mental disorders as unpredictable, violent and incompetent (Atilola & Olayiwola, 2011). Stigma is known to have many implications across different aspects of one's life including help-seeking behaviors (Bowers, Manion, Papadopoulos & Gauvreau, 2013). Most mental disorders and difficulties initially manifest during adolescence and affect approximately 20% of children and youth (Kessler, Berglund, Demler, Jin, Merikangas & Walters, 2005).

Einsberg, Downs, Golberstein and Zivin (2009) and Yap and Jorm (2011) found that younger students had more stigmatizing attitudes compared to older generations. Thus, there is an urgent need to tackle stigma in younger individuals in order to improve mental health services and promote early intervention. Although stigma has been recognized as an important area in child and adolescent research, the construct remains under-conceptualized and must be a central concern to psychologists (Heflinger & Hinshaw, 2010). Attempts to address the issue of stigma include anti-stigma interventions in the form of educational approaches, protests, and contact-based methods (contact between the general population and individuals suffering from mental health disorders and difficulties) (Corrigan & Penn, 1999;

Corrigan & Watson, 2004; Schachter, Girardi, Ly, Lacroix, Lumb, Van Berkom & Gill, 2008; Wei, Hayden, Kutcher, Zygmunt & McGrath, 2013).

Moreover, culture refers to the common attributes, belief systems and values shared by a group of people which influences their customs, norms, psychological processes and organizations (APA, 2003; Fiske, Kitayama, Markus & Nisbett, 1998). To this end, Rao, Feinglass & Corrigan (2007) reasoned that, "diagnoses of mental illnesses are given based on deviations from sociocultural, or behavioral norms. Therefore, mental illness is a concept deeply tied to culture and accordingly, mental illness stigma is likely to vary across cultures" (p.1020). Hence, the underlying causes and behaviors of stigmatization manifest themselves differently from one culture to the other.

1.2 Stigma and Mental Health

In May 2013, the World Health Organization stated its vision: 'a world in which mental health is valued, promoted and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high quality, culturally-appropriate health and social care in a timely way to promote recovery, all in order to attain the highest possible level of health and participate fully in society and at work free from stigmatization and discrimination' (p.2). Nevertheless, over the past few decades, mental health related stigma has increased steadily (Evans-Lacko, Courtin & Fiorillo, 2014).

The Greek origin of the word stigma referred to marks or burns on an individual's body that characterized them as unusual, immoral or bad, thus, signifying that they should be avoided (Goffman, 1963). Stigma is an attribute that discredits individuals and reduces the person's status from a "whole and usual person to a tainted, discounted one" (Goffman, 1963, p.3). In relation to mental illness, stigma refers to the degradation and social judgment one experiences from the public in response to their illness and difficulties. More recently, stigma was defined by Pescosolido, Martin, Land and Olafsdottir (2008) as "a mark separating individuals from one another based on socially conferred judgment that some persons or groups are tainted and 'less than'" (p.431).

Individuals who are presumed to be experiencing symptoms of mental health difficulties of any type are associated with unfavorable stereotypes (Jones, Farina, Hastorf, Markus, Miller & Scott, 1984) and experience status loss, discrimination, separation and labeling (Link & Phelan, 2001). According to Corrigan et al. (2000) and Thompson et al. (2002), the public perceives mental illness as most disabling in comparison to other conditions, including physical disabilities. Thus, the stigma associated with mental illness exceeds that of any other condition. In 2006, Mathers and Loncar stated that within the next two decades, mental health problems are predicted to be the largest burden of illness globally. That being said, the Surgeon General's report on mental health stated that stigma "is the most formidable obstacle

to future progress in the arena of mental illness and health" (Hinshaw, 2007; U.S Department of Health & Human Services, 1999).

1.2.1 Public Stigma and Self-Stigma

Stigma is considered a multidimensional phenomenon and includes the concepts of public stigma and self-stigma (Corrigan & Watson, 2002). Public stigma refers to the shared stereotypes held by the public towards people suffering from mental health difficulties and disorders (Link, 1987) while self-stigma refers to the internalization of such stereotypes and the application of such beliefs to oneself (Corrigan, 2002). The consequences of each of these concepts may differ. For instance, public stigma leads to a decrease in help-seeking behaviors (Wrigley, Jackson, & Judd, 2005) while self-stigma directly impacts the individual's feelings of self-esteem and self-efficacy (Corrigan, Watson, & Barr, 2006; Rusch, Angermeyer, & Corrigan, 2005). This study focuses on the concept of public stigma, however, self-stigma is briefly discussed in this section in order to highlight the importance of considering the phenomenon.

1.2.1.1 Public Stigma

Public stigma refers to the general population's negative stereotypes towards people suffering from mental illnesses and is viewed as a form of prejudice compromised of cognitive, affective and behavioral reactions (Corrigan, Watson,

Gracia, Slopen, Rasinski & Hall, 2005). Common affective reactions include a sense of fear, irritation, and a lack of sympathy towards people with a mental illness (Martin, Pescosolido, Olafsdottir & Mcleod, 2007). Additionally, studies conducted in Western countries identified stereotypes commonly held by the general public such as people with mental illnesses are viewed as dangerous, violent, and unpredictable (Lauber, Nordt, Braunschweig & Rossler, 2006). Moreover, the general population encouraged measures that restricted civil rights and freedom of those suffering from mental health problems (Lauber, Falcato, & Rossler, 2000). For instance, the public believe that any person with a mental illness should be compulsorily hospitalized, people with mental illnesses should not have a driver's license, and pregnant women with a history of mental illness should be recommended for abortions (Lauber, Nordt, Falcato, & Rossler, 2001).

The conceptualization of mental illness stigma is highlighted in two leading theoretical models, the first by Corrigan and Watson (2002): a social psychological perspective on public stigma; and the second by Link and Phelan (2001): a sociological concept of the stigma process. An emphasis is placed on Corrigan and Watson's (2002) model which suggests that public stigma consists of three elements: stereotypes (cognitive knowledge structures), prejudice (cognitive and emotional consequences of stereotypes) and discrimination (behavioral consequences of prejudice). Stereotypes are knowledge structures shared by most members of a social group (Hilton & Von Hippel, 1996) and they generate impressions and expectations of people who belong to a stereotyped group (Hamilton & Sherman, 1996). While some

members may be aware of a stereotype, they do not necessarily agree with them (Jussim, Nelson, Manis & Soffin, 1995). However, a prejudiced person will endorse such negative perceptions and experience negative emotional reactions as a result (Tesser, 1995; Hilton & Von Hippel, 1996). Consequently, prejudice leads to discriminatory behaviors by the general public who are less likely to hire someone with a mental illness (Bordieri & Drehmer, 1986; Farina & Felner, 1973), more likely to falsely press charges for violent crimes (Sosowsky, 1980; Steadman, 1981) and less likely to lease them apartments (Page, 1995).

1.2.1.2 Public Stigma and Attribution Theory

Corrigan (1998) and Crocker and Lutsky (1986) identified three main paradigms that attempt to portray the influence of stigma: Sociocultural Perspectives (stigmas develop to justify existing social injustices), Motivational Biases (stigmas develop to meet basic psychological needs), and Social Cognitive Theories (stigmas are the products of processing human knowledge structures). An emphasis is placed on Social Cognitive Paradigms due to their prominence in providing a broad theoretical base and empirically tested intervention approaches to understand and alter stigma at a societal level (Augoustinos & Ahrens, 1994; Esses, Haddock & Zanna, 1994). The model aims to highlight the connection between discriminative stimuli and resulting behaviors by recognizing the cognitions that liaise these constructs: discriminative stimuli lead to cognitive mediators which in turn lead to behavioral responses (Corrigan, 2000).

Attribution theory is a theory of social cognition which is utilized in order to understand the public's reactions towards people with mental disorders (Corrigan, Markowitz, Waston, Rowan & Kubiak, 2003; Martin, Pescosolido & Tuch, 2000). The theory hypothesizes that individuals make causal attributions about others behaviors which generate certain emotions and subsequently guide reactive behaviors (Weiner, 1985, 1986). Attribution research focuses on identifying constructs that impact causal attributions. In relation to mental health stigma, research has identified two consistent constructs that explain human motivation: stability of causes and controllability of causes (Weiner, 1993, 1995).

Stability of causes refers to the temporal aspect of cause (Weiner, 1995), with some causes remaining powerful and potent over time while others weaken and diminish. Research suggests that attributions about the stability of a cause affect the strength of reactions rather than the type of behavioral and emotional responses (Barnes, Ickes & Kidd, 1979; Weiner, Graham & Chandler, 1982). Moreover, more weight is given to causal attributions which are viewed as stable and unchanging rather than fluctuating. For instance, schizophrenia was traditionally viewed as an illness that is stable and rarely improving over time, as a result, hope for the future was negligible (Anthony, 1994). Contrary to traditional notions, people suffering from mental illness benefit from treatment and are able to sustain a balanced life (Corrigan, 2000). However, false perceptions have a powerful impact on individuals' reactions and thus need to be altered, especially in the face of contrary evidence.

Controllability of causes was identified by Anderson and Arnoult (1985) as the most important causal dimension amongst the various dimensions of causal attribution proposed by Weiner (1985). Controllability refers to the amount of volitional influence one exerts over a cause (Weiner, 1985, 1995). People are more likely to assign blame and responsibility to events that are viewed as controllable by the individual (Corrigan, 2000). Weiner's theory suggests that people who are viewed to be in control of a negative event (symptoms of an illness), are more likely to be held responsible for the occurrence, and experience reactions of anger from the public (Dooley, 1995; Rush, 1998). Similarly, individuals that believe they are in control of negative events experience feelings of shame and guilt (Brown & Weiner, 1984), while those who are not believed to be in control of a negative event experience reactions of pity by others (Dooley, 1995; Schmidt & Weiner, 1988).

As previously mentioned, in the case of controllable causes, reactions of anger are greater, whereas pity is greater when an individual's behavior is perceived as uncontrollable (Weiner et al., 1982). A study conducted by Louise Dolphin and Eilis Hennessy (2014) aimed to examine adolescents' perceptions of a peer with depression in relation to an attributional model. They suggest that stigma towards a peer with a mental disorder is influenced by attributions about the causes of their illness and assumptions around personal responsibility. Their findings indicated that responsibility is not inferred when the peer with depression is perceived as having little control over the cause of their illness. Thus, participants sympathized with, and

pitied the individual, and they were more likely to socially accept them. Although it has been found that emotions of anger/irritation and peer exclusion were not significantly correlated, conflicting evidence by Juvonen (1991), found that children's negative emotions did not predict willingness to provide social support for a peer with depression.

Overall, the results of the study indicated that adolescents were more likely to accept a peer with depression based on low attributions of personal control over the illness (Dolphin & Hennessy, 2014). Based on the assumptions of attribution theory, some theorists suggest that attributing mental disorders to the medical model may reduce stigmatizing attitudes as it reduces perceptions of personal control (Corrigan & Watson, 2004; Hinshaw & Stier, 2008). Conversely, findings of a meta-analysis (Kvaale, Gottdiener & Haslam, 2013) indicated that the medicalization of mental disorders revealed mixed outcomes. They found that individuals that held biological explanations for mental disorders were less likely to blame people with mental illnesses for their problems, however, they were more likely to desire more distance from them. In addition, the effects of environmental factors are overlooked in this situation and the view that mental disorders have uncontrollable components may lower the expectation of recovery and reduce willingness to seek help (Corrigan & Watson, 2004).

1.2.1.3 Self-Stigma

The distinction between public stigma and self-stigma has been useful in identifying the unfavorable effects of each one of these concepts on people suffering from mental health disorders (Corrigan, 2004). Self-stigma occurs when people suffering from a mental illness internalize the negative stereotypes and suffer the consequences of applying such attitudes to oneself, resulting in diminished self-esteem and a decrease in self-efficacy (Corrigan, Watson & Barr, 2006). Corrigan, Larson and Rusch (2009) explore the consequences of self-stigma and refer to the outcomes as the "why try" effect. The latter suggests that individuals that apply such stereotypes on themselves tend to believe that they are unable to meet the demands of a particular task, such as applying for a job, and consequently decide to avoid the task.

Previous research focused on stigma and discrimination by the community and health systems towards people with mental disorders (Brohan, Gauci, Sartorius & Thornicroft, 2011; Rusch, Corrigan & Wassel, 2009). However, recent studies shifted the focus to examine the influence of self-stigma wherein the individual adopts a devalued view of themselves which reflects the dominant social perceptions towards people with mental illness (Yanos, Lucksted, Drapalski, Roe & Lysaker, 2015). Self-stigmatization has a powerful negative influence on an individual's overall health and well-being with outcomes such as low self-esteem, low levels of recovery and increased risk of suicide being linked to the phenomenon (Assefa, Shibre, Asher & Fekadu, 2012; Barke, Nyarko & Klecha, 2011). Moreover, several sociodemographic factors such as age, marital status, employment status and perceived quality of life

have been associated with the risk of self-stigma (Branka, Jakovljevic, Ivanec, Margetic & Tosic, 2010; Gerlinger, Hauser, Hert, Lacluyse, Wampers & Correll, 2013).

Major and O'Brien's (2005) theoretical model 'identity threat model of stigma' explains the internalizing of stigma. The model suggests that stigma affects the stigmatized individual through experiences of discrimination, expectancy confirmation (anticipated stigmatizing events) and automatic stereotype activation (reinforcement of cultural stereotypes) (Major & O'Brien, 2005). Subsequently, the stigmatized individual might accept the public perceptions around their position in society, including an awareness of being devalued. Thus, impacting their perceptions of certain situations even in the absence of discriminatory behavior (Crocker, 1999). However, while individuals with mental disorders may acknowledge the existing stereotypes around their group, they may not agree with them, thus, knowledge alone does not necessarily lead to self-stigma (Crocker & Major, 1989).

1.3 Mental Illness Stigma in Adolescence

1.3.1 Stigma and the Youth

Efforts to reduce mental illness stigma come in the form of education, contact based interventions and protests against stigmatizing messages (Corrigan, Morris, Michaels, Rafacz & Rusch, 2012). Most anti-stigma efforts focus on educating adults (Hinshaw, 2005), however, from a developmental perspective, the tendency to

stigmatize emerges during middle childhood and intensifies with age (Wahl, Hanrahan, Karl, Lasher & Swaye, 2007). In accordance, Augoustinos and Rosewarne's (2001) empirical work on children's social cognition suggests that awareness of personal and societal stereotypes develop by middle childhood. However, mental illness stigma in childhood and adolescence is relatively under-researched (Hinshaw, 2005; Mukolo, Heflinger, & Wallston, 2010). The persistence of mental illness stigma in adolescence may likely impact many areas of their lives such as help seeking behaviors (Bowers et al., 2013), the quality of support provided by peers (Yap & Jorm, 2011) and the achievement of their academic goals (Hinshaw, 2005).

One of the most common stereotypes is the belief that people with mental illnesses are dangerous (Phelan, Link, Stueve & Pescosolido, 2000). This belief results in fear, which in turn leads to avoiding the individual with a mental disorder (Angermeyer & Matschinger, 1996). Younger individuals tend to associate mental illness with violence and are more fearful compared to adults (Crisp, Gelder, Rix, Meltzer & Rowlands, 2000; Pinfold, Huxley, Thornicroft, Farmer, Toulmin & Graham, 2003). According to Taylor and Dear (1981), social restrictiveness is the belief that people with mental illness are dangerous and are to be avoided or restricted; on the other hand, benevolence is the expression of sympathy towards people with a mental illness and the acknowledgment that the public is responsible of supporting them. Studies have shown that education predicted more accepting and positive attitudes such as benevolence, while low education predicted negative attitudes such as social

restrictiveness (Ikwuka, Galbraith, Manktelow, Chen-Wilson, Oyebode & Muomah, 2016). While high education is a predictor of less discriminatory behaviors and higher treatment optimism (Richmond & Foster, 2003), mental health education specifically has a more significant impact on decreasing stigma and increasing positive attitudes (Alexander & Link, 2003; Hogberg, Magnusson, Ewertzon & Lutzen, 2008).

Young people with mental health difficulties report experiencing stigma from their peers (Moses, 2010). Research from U.K.'s 'Time to Change' program investigated the consequences of stigma in adolescence and their results indicated that 40% of students reported that stigma stopped them from going to school, 54% stopped socializing with friends and 26% considered suicide (Time to Change, 2012). The youth are an important target for raising knowledge and awareness around mental health issues given that the onset of a variety of mental disorders and difficulties arise during adolescence (Amminger, Harris, Conus, Lambert, Elkins, Yuen & McGorry, 2006; Oakley Browne, Wells, Scott & McGee, 2006). Nevertheless, adolescents are less likely to seek support and access mental health services due to stigma (Biddle, Gunnell, Sharp & Donovan, 2004). Moreover, previous research on adolescents' mental health literacy indicated that less than 50% of young people aged 15-25 were able to identify depression, and only a quarter were able to identify psychosis (Wright, Harris, Wiggers, Jorm, Cotton, Harrigan, Hurworth & McGorry, 2005).

1.3.2 Approaches to Decrease Stigma

Approaches to decrease mental illness stigma include protests, education and contact (Corrigan & Penn, 1999). Protests aim to highlight the injustices caused by stigma and chastise people that discriminate. Wahl (1995) reported anecdotal evidence suggesting that protests can positively influence unfavorable behaviors. For instance, StigmaBusters is a group of the National Alliance on Mental Illness (NAMI) with over 15,000 advocates who work together to challenge stigmatizing images represented in the media (Corrigan & Watson, 2004). In the year 2000, StigmaBusters played a significant role in persuading ABC to cancel the show 'Wonderland' which portrayed people with mental illness as dangerous and unpredictable. While protests can have positive influences, there is some evidence which suggests that protest campaigns that ask people to suppress their prejudice may produce adverse effects where prejudices about a group remain unchanged or worsen (MacRae, Bondenhausen, Milne & Jetten, 1994; Wegner, Erber & Zanakos, 1993).

Educational approaches aim to challenge inaccurate stereotypes about mental illnesses by replacing them with factual information, these include public service announcements, books, flyers, movies, podcasts and informative talks (American Psychiatric Association, 1994; Finkelstein, Lapshin & Wasserman, 2008). Research on educational approaches reported short-term improvement in attitudes related to dangerousness and blame (Arboleda-Florez & Sartorius, 2008), however the magnitude and duration of improvement may be limited (Corrigan & McCracken,

1997). The third strategy is interpersonal contact with a stigmatized group. Individuals who interact with people with mental disorders and difficulties are likely to show decreased prejudice (Corrigan, 2005). Corrigan et al. (2003) demonstrated that attitude and behavior change after contact is maintained over time. However, not all contact is effective. A meta-analysis by Corrigan et al. (2012) which included 79 intervention studies that addressed public stigma suggested that educational and contact approaches were effective in reducing stigma. However, their results showed that although contact was the most effective approach for adults, this was not the case for adolescents who benefited significantly more from educational approaches that did not include contact (Corrigan et al., 2012).

1.3.3 Educating the Youth

There have been worldwide efforts to eliminate and decrease mental health stigma (Sartorius & Schulze, 2005; Kirby & Keon, 2006) through various interventions that have been developed to prevent discrimination (Angermeyer & Holzinger, 2005; Crisp, 2003; Pickenhagen & Sartorius, 2002). According to Schachter, Girardi, Ly, Lacroix, Lumb, Van Berkom and Gill (2008), the most effective strategies entail early and developmentally-appropriate school-based interventions since schools grant access to the largest gatherings of receptive younger citizens. The results of their systemic review indicated that school-based approaches encourage the development of empathy and promote social inclusion which, in turn, prevents the emergence of, and eliminates discriminatory attitudes in students (Schachter et

al., 2008). Mental health literacy involves knowledge and skills that address the biological, psychological and social aspects of mental health in order to increase knowledge on mental health disorders, recognize and prevent mental health difficulties and facilitate help-seeking behaviors in adolescents (Wei & Kutcher, 2012; Wei, Kutcher & Szumilas, 2011).

Wei, Hayden, Kutcher, Zygmunt and McGrath (2013), conducted a systemic review on the effectiveness of school mental health literacy programs which aim to enhance knowledge, reduce stigmatizing attitudes and improve help-seeking behaviors among youth. Their systemic review included twenty-one studies conducted in secondary schools and six in post-secondary schools. Fourteen studies took place in the USA, five in the U.K., two in Germany, two in China, two in Canada, one in Serbia, one in Australia and one in Pakistan, however, no studies were conducted in the Middle East with Arab students (Wei et al., 2013). Overall, the findings indicated that twelve of fifteen studies demonstrated a statistical significant increase in knowledge, twenty-one studies addressed attitudes towards mental illness with fourteen of these studies observing a significant decrease in stigma, and eight studies addressed help-seeking behaviors, three of which reported mixed findings. Although it has been found that school based interventions promote knowledge and decrease stigma, this area of research is still in its infancy and there is insufficient evidence to determine which methods work best (Wei et al., 2013). Therefore, future research should focus on strategically targeting groups who have importance in terms of the efforts to change stigma, such as adolescents (Corrigan, Roe & Tsang, 2011).

Moreover, there is a need to investigate the attitudes of adolescents in populations that lack such research in order to gain a deeper understanding of factors that contribute to mental health stigma, such as culture, religion, socio-economic status, and develop specific interventions accordingly.

A study conducted in Japan (Ojio, Yonehara, Taneichi, Yamasaki, Ando, Togo, Nishida & Sasaki, 2015) developed a concise, school-staff-led mental health literacy program with the aim to improve knowledge and beliefs around mental health in students. Several countries introduced mental health literacy programs in their schools, however, most of these programs were highly time consuming (Ojio, Togo & Sasaki, 2013; Wei at al., 2013; Yamaguchi, Mino & Uddin, 2011). Therefore, short-term interventions may be more beneficial due to tight schedules that include heavy demands of the regular curriculum as well as extra-curricular activities (Han & Weiss, 2005; Santor & Bagnell, 2013). Ojio et al.'s (2015) brief intervention consisted of two 50-minute sessions that were given one week apart and included standard instructions, animations and group discussions. Results of the study demonstrated a significant increase in knowledge and beliefs about mental health/illnesses, their treatment and the intention to seek help as well as to support peers with difficulties. Ojio et al. (2015) also reported the very limited number of brief school-based educational interventions.

Similarly, Pinfold, Toulmin, Thornicroft, Huxley, Farmer and Graham (2003) developed a concise school-based educational program of two 60-minute sessions for

secondary school students using a short video, lecture and information leaflets in addition to contact with an individual with a mental disorder. The program positively influenced knowledge and attitudes, however, contrary to Ojio et al. (2013), their program was delivered by a mental health professional. Overall, both studies highlight the advantages of school-based short-term educational interventions conducted by mental health professionals or trained school staff in yielding more accepting and understanding attitudes in students. Only a small number of programs led by school staff have been developed and showed significant improvements in student's knowledge and attitudes (McLuckie, Kutcher, Wei & Weaver, 2014; Naylor, Cowie, Walters, Talamelli & Dawkins, 2009; Petchers, Biegel & Drescher, 1988). While these long programs may have greater effects, they may be less sustainable due to being over prolonged for a school setting. Moreover, programs studying the effect of short-term or long-term educational interventions should include a control group. While some researchers may argue that short-term interventions do not produce long-term effects, Ojio et al. (2015) reported that the positive effects of their program were maintained three months after the program.

Emerging evidence confirmed that school-based programs which aim to reduce stigma and improve knowledge additionally improved participants' mental health and resilience (Kelly, Jorm & Wright, 2007). A study conducted by Chisholm, Patterson, Torgerson, Turner, Jenkinson and Birchwood (2016) investigated whether contact in addition to education was more effective than education alone in reducing stigma. Their intervention consisted of a one-day educational program led by mental health

professionals with a total of 769 participants. The results of the study indicated that participant's knowledge and attitudes in the education-alone condition improved significantly more than participants in the contact and education condition. Similarly, participants in the education-alone condition displayed greater improvement in knowledge two-weeks post-intervention compared to the participants in the contact and education condition. Moreover, participants in the education alone condition had greater improvement in levels of emotional well-being as well as willingness to seek help compared to participants in the contact and education condition. These results are in line with a meta-analysis conducted by Corrigan et al. (2012), and conflict with only three previous studies which promoted the benefits of contact and education interventions (Chan, Mak & Law, 2009; Husek, 1965; Meise, Sulzenbacher & Hemler, 2000). Another study confirmed the advantages of an educational approach through the evaluation of eighteen Canadian anti-stigma programs targeting high school students (Chen, Koller, Krupa & Stuart, 2015). The results showed that programs with the strongest changes in stigma outcomes were educational in nature, with the contact aspect additionally focusing on education.

1.3.4 Theory of Planned Behavior

While education based interventions promote more accepting attitudes and enhance understanding of mental health illnesses and difficulties in adolescents, changes in knowledge and attitudes do not reliably predict behavior (Chung & Chan, 2004; Herbert, Voyer & Valois, 2000; Tolomiczenko, Goering & Durbin, 2001). Brief

educational interventions on mental illness have been proven to reduce stigmatizing attitudes among police officers (Pinfold et al., 2003), industrial workers and government employees (Tanaka, Ogawa, Inadomi, Kikuchi & Ohta, 2003) and high school students (Esters, Cooker & Ittenbach, 1998). However, research on educational programs suggest that behaviors are often not assessed. The theory of planned behavior suggests that behavior is more accurately determined by behavioral intentions and the motivation to engage in a certain behavior (Ajzen, 1991). According to Ajzen (1991) three factors determine the strength of a behavioral intention: *attitude:* the extent to which an individual views the planned behavior as favorable or unfavorable; *subjective norm:* refers to the perceived social pressure to either perform or not perform the behavior; *perceived behavioral control:* refers to the perceived difficulty or ease of performing the behavior.

According to the theory of planned behavior (Ajzen, 1991), individuals are more likely to engage in the behavior if they have positive attitudes towards it. Therefore, promoting more favorable attitudes towards people with mental illnesses through education may have a beneficial impact on people's behaviors. Additionally, individuals are more likely to engage in the behavior if people whose views they value encourage them to do so. Thus, changing the general public's views and attitudes towards mental health and mental illness may impact future generations. Lastly, individuals are more likely to engage in the behavior if they feel as though they have the necessary support, resources and opportunities to do so. Hence, education around mental health and mental illness should include techniques on how to support

those suffering from mental health difficulties, how to access services for one's own needs, and an acknowledgment of positive outcomes in seeking support.

1.4 Mental Illness Stigma in the Arab Population

1.4.1 Attitudes towards Mental Illness in the Middle East

According to the Mental Health Atlas (2011), mental health services in the Middle East, including Kuwait, are inadequate, neglected and deeply stigmatized. Stigma has been identified as a fundamental barrier to seeking mental health treatment (Al-Krenawi, 2005). Given the collectivist nature of the Arab population, current research identified that Arab youth with mental health difficulties are often reluctant to seek treatment due to the fear that they may be perceived as weak or bring shame to one's family (Al-Darmaki, 2003; Al-Krenawi, 2005; Hijawi, Elzein Elmousaad, Marini, Funk, Skeen & Al-Ward 2013; Sayed, 2002). Moreover, in response to public stigma around mental illness, Arab families tend to conceal the mental disorder of a family member or otherwise delay or deny treatment (Saxena et al., 2011; Shibre, Negash, Kullgren, Kebede, Alem & Fekadu 2001). Okasha (1999) highlighted the tendency of Egyptian youth to avoid treatment and express depression through somatic symptoms due to the greater social acceptance of physical disability. Moreover, men associate seeking formal help with a diminished sense of masculinity and abilities to be strong providers and family leaders (Al-Issa, 2000; Al-Krenawi & Graham 2000; El-Islam, 2000).

Negative attitudes towards mental illness are common and result in social distance, isolation and rejection (Angermeyer, Matschinger & Corrigan 2004; Coker, 2005; Ozmen et al., 2004). Due to the collectivist nature of the Middle Eastern society, social isolation has been equated to death (Coker, 2005). Most of the approaches to challenge stigma were developed and adapted for Western communities. Stigma is embedded in its' social context; what may be acceptable in one society may be unacceptable and stigmatized in another society (Abdullah & Brown, 2011). To date, little is known about mental illness stigma in the Arab culture, thus, making it difficult to develop interventions to challenge this issue (Dardas & Simmons, 2015). Furthermore, most Arab countries lack mental health legislations, such as Kuwait, or documented mental health policies (Al-Krenawi, Graham & Dean, 2004). Many Arab countries have been experiencing, directly or indirectly, years of conflict, suppression and human rights violations, which in turn leads to higher rates of mental health problems (Amawi, Mollica, & Lavelle, 2014). Additionally, the Arab Spring which began in 2010 and is still present, is expected to substantially impact Arabs' mental health and well-being (Amawi et al., 2014).

Arabs tend to hold negative views towards formal psychological and psychiatric services and have little knowledge on the existence of such services and the role of their providers (Al-Qutob, 2005). Moreover, Al-Krenawi and Graham (2000) suggested that the majority of Arabs view mental health professionals as a single unit that discard religious values, lack genuineness and empathy with personal

experiences, and with whom it is difficult to establish trust. A study conducted by Gilat, Ezer and Sagee (2010) revealed that in the presence of mental illness, Arabs tend to turn to family practitioners first (33%), followed by family members (21.6%), then the Sheikh (19%), and lastly, mental health practitioners (11%). However, according to Al-Krenawi (2005), mental health difficulties and disturbances are generally tolerated by Arabs as long as they do not result in shameful or out of control behaviors. El-Islam (1994) highlighted the notion of 'associative stigma' in Arabian Gulf countries which refers to the social shame associated with a family member's diagnosis, suggesting that abnormal behavior brings social shame to the individual, but most importantly to the family.

In the Arabic language the word 'Alwasm' is derived from the word 'Wasmah' which means the process of easily identifying places or objects by attaching signs to them, therefore, referring to the meaning implied in the concept of stigma (Dardas & Simmons, 2015). In other words, it means attributing social shame to individuals due to their illness and their behaviors which are perceived as unacceptable. The association of craziness with mental disorders is common in the Arabic culture. Similarly, Youssef and Deane (2006) stated that in the Arabic language psychological disorders are translated into "Amradh Nafsiah" (illness of the self) while mental disorders are translated into "Amradh Aqliah" (illness of the brain or mind). "Aqil" which means mind or brain, refers to one's sanity, therefore, any disturbances involved with the "Aqil" leads to becoming the opposite which is "Jonoon" (insanity or absence of reason). Therefore, the semantic overlap in the Arabic language between

mental disorders and being sane has associated insanity with mental disorders (Youssef and Deane, 2006).

A study conducted by Mousa and Fares (2005) examined 12 cases of depressed Iraqi adolescents and reported that despite their knowledge on the importance of seeking and adhering to treatment, the stigma they experienced significantly compromised their willingness to seek support. In addition, Kadri, Manoudi & Berrada (2004) studied 100 Arab family members of relatives with schizophrenia and found that 86.7% of family members reported hard lives and 72% reported mental suffering and poor quality of life due the presence of a mental illness in a family member. It is noted that Arab families typically get involved in the course of treatment (Eapan and Ghubash, 2004; Sayed, 2003). Conflicting evidence suggested that having a family member with a mental illness can lead to positive gains such as personal growth, increased awareness, improved relationships with others, greater compassion and understanding, increased patience and empathy and the development of new coping strategies (Dardas & Ahmad, 2015; Hastings & Taunt, 2002; Kayfitz, Gragg & Orr, 2010). Thus, the importance of integrating psycho-education into clinical practice (Alosaimi, Alshehri & Alfraih, 2014).

A study conducted in Jordan examined stigma perceptions of mental health treatment for Arab adolescents managing depression (Gearing, MacKenzie, Ibrahim, Brewer, Batayneh & Schwalbe, 2014). The findings of the study indicated that participants were more willing to accept adolescent males with depression in their

child's school than females with depression. Moreover, participants were less likely to hire females receiving treatment than either males or untreated females. Gender has been repeatedly identified as a barrier to mental health treatment in the Arab culture (Gearing, Schwalbe, MacKenzie, Brewer, Ibrahim & Olimat 2013). The disclosure of abuse and mental disorders in young Arab females is usually identified while seeking treatment, this leads to stigmatizing attitudes that may damage marital prospects or affect current marital relationships (Al-Krenawi & Graham, 1999; Gearing et al., 2013; Shalhoub-Kevorkian, 2005). Moreover, the study found that acceptance of people with mental illness increased as the relationship became less intimate and more generic (Gearing et al., 2014). Similarly, a study conducted in Turkey by Ozmen, Ogel, Aker, Sagduyu, Tamar & Boratav (2004) found that stigma and rejection worsened in personal and intimate situations, such as attending school, working with, or residing near a person with depression; whereas acceptance increased in public or impersonal domains.

Al-Darmaki, Thomas and Yaaqeib (2015) explored beliefs around mental health amongst female Emirati college students due to the high prevalence of depression and anxiety amongst women in the Arabian Gulf. The results of their study indicated that social and environmental factors were the dominant explanation for psychological problems. The individual suffering from a mental health difficulty was seen as responsible for their condition due to their thought process (negative thinking and over-thinking). Moreover, they were viewed as having weak personalities, low self-confidence and unhealthy lifestyles, suggesting that individuals with psychological

problems were viewed negatively (Al-Darmaki et al., 2015). Participant's responses (36.5%) also identified stigma as the main barrier for seeking treatment due to a fear of being labeled as crazy. Additionally, shame and embarrassment, low awareness and lack of knowledge around mental health issues was viewed as another barrier for seeking proper treatment.

1.4.2 Religion and Mental Illness

The Holy Quran states:

'...Let not some men among you laugh at others, It may be that the latter are better than the former, Nor let some women laugh at others, It may be that the latter are better than the former, Nor defame nor be sarcastic to each other, nor call each other by offensive nicknames, ... And those who do not hesitate are indeed doing wrong' (Al-Hujuraat, 11).

This verse of the Quran advises people to refrain from activities that include hatred and which may cause disruption in the society. While some may consider mockery and name-calling to be harmless, it is considered a sin. Such attitudes and behaviors also apply to the ways in which people treat individuals with mental health issues. Informing those who are religiously inclined about the harms of stigmatizing behaviors and attitudes may be a helpful tool in reducing stigma within such communities.

While mental illness remains largely stigmatized within the Arab population, individuals within the society are more inclined to visit religious healers to cope with mental illness (Al-Darmaki & Sayed, 2009; Al-Krenawi, 2005; Hamid & Furnham, 2013). The latter is due to less stigmatizing views in seeking help from religious healers compared to seeking psychological treatment (Youssef & Deane, 2006). Twenty-two Arab countries recognize Islam as the dominant religion with more than 90% of Arabs identifying as Muslims (Nydell, 2005). Arab Muslims tend to believe that mental illnesses result from possession by evil spirits known as 'Jinn' (Aloud & Rathur, 2009; Weatherhead & Daiches, 2010). Additionally, Fadlalla (2005) found that the concept of the evil eye which is considered as a powerful jealous look or comment upon the good fortune of another, was believed to cause mental illnesses, physical ailments or failure in business or relationships.

According to Youssef and Deane (2006), Arab Muslims are less likely to stigmatize mental illness if they believe it is caused by the possession of an evil spirit 'Jinn', or the evil eye 'Hasad'. It is also believed that a mental illness is a test from God or a result of God's will, therefore only God may cure the illness. While these beliefs may de-stigmatize mental disorders, other beliefs such as the illness being viewed as a punishment for one's sins or a result of one's weak faith, may induce stigma (Weatherhead & Daiches, 2010). In response to such beliefs, Dardas and Simmons (2015), believe that there is a need to promote awareness through including mental health education in academic curricula. Moreover, due to the belief that mental illness is potentially caused by evil spirits or the evil eye (Al-Adawi et al.,

2002; Al-Darmaki & Sayed, 2009; Owen & Ciftci, 2009) there is a perception that men with mental health issues may be stigmatized as a result of their inability to carry out their responsibilities as they are viewed as being less powerful and less dominant within the society.

Al-Krenawi et al. (2008) suggested that due to the perception of mental health systems representing Western culture, they may be perceived as ignoring Arab Islamic values, therefore impeding the acceptance of mental health services. Hence, they aimed to target university students in their study in order to bridge the gap between local traditions and modernized forces as they believe education provides an exposure to ideas outside one's culture (al-Krenawi et al., 2008). A verse in the Holy Quran states: '*... If ye realize this not, ask of those who possess the Message*' (Al-Nahl, 43) which signifies that if one does not possess the answers to a certain topic, one must ask those who are specialist in the topic. In other words, Muslim Arabs may be advised to seek a specialist's support or knowledge from mental health professionals rather than relying on traditional and nonscientific methods of treatment.

1.4.3 Mental Health in Kuwait

Through a consultation with the World Health Organization, Kuwait identified mental health as one of six strategic priorities to integrate mental health services into primary health care and develop community and home-based services (World Health

Organization, 2014). However, it is highly acknowledged that there is very limited research available in the region to guide contextually-appropriate development of mental health services (World Health Organization, 2010; Supreme Council of Health, 2013). Hickey, Pryjmachuk and Waterman (2016) conducted a review of mental health research in the Gulf Cooperation Council (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates), with fifty-five studies meeting the inclusion criteria. Their findings indicated that the concept of stigma is conspicuously absent from the articles and very little effort has gone into measuring and describing stigma towards mental illness in the Gulf, and more specifically, in Kuwait (Hickey et al., 2016). Almazeedi and Alsuwaidan (2014) also identified the lack of research on stigma in Kuwait in their article 'Integrating Kuwait's Mental Health System to end Stigma: A Call to Action".

The mental health system in Kuwait is structured around one public psychiatric hospital that includes 48 psychiatrists, 17 psychologists, 8 social workers and 294 psychiatric nurses. Fourteen other psychiatric outpatient clinics are located in five regional hospitals as well as prisons and schools (World Health Organization, 2001). Although it has been shown that individuals prefer that psychiatric facilities be located away from the community (Al-Adawi, Dorvlo & Al-Ismaily 2002) it is believed that the integration of psychiatric and psychological services in the primary health care would reduce stigmatizing attitudes (World Health Organization, 2001),

A study conducted in Kuwait aimed to estimate the prevalence of depressive disorders and the influence of sociodemographic characteristics in primary healthcare settings (Al-Otaibi, Al-Weqayyan, Taher, Sarkhou, Gloom, Aseeri, Al-Mousa, Al-Zoubi & Habeeba, 2007). Their findings indicated that 37% of 2,320 participants screened positive for depressive symptoms, with 7% being severely depressed, 13.5% moderately depressed and 16.5% mildly depressed (Al-Otaibi et al., 2007). Correspondingly, a study conducted in Saudi Arabia indicated that the point prevalence of depression was 49.9% (Al-Qadhi, Urrehman, Ferwana & Abdulmajeed, 2014). Due to the high prevalence of depressive symptoms within the community, it is crucial to educate the population on such issues as well as available resources and services to seek professional help.

Okasha, Karam and Okasha (2012) summarized the current situation of mental health services in the Arab world and suggested that although Kuwait is one of the Arab countries with the most psychiatrists, psychologists and social workers, health and education budget assignment is below the recommended requirements for better quality of life. However, Kuwait's annual per capita health expenditures are estimated to be $552 (Al-Krenawi, Graham, Al-Bedah, Kadri, Sehwail, 2008). Moreover, the aftermath of the Gulf War is believed to be strong, thus highlighting the need for psychological counselling and support in Kuwait (A-Krenawi et al., 2008).

Al-Krenawi et al. (2008) investigated student's help-seeking behaviors and attitudes towards perceived cultural beliefs and mental health problems in Kuwait,

Egypt, Palestine and Israeli Arab communities. Their findings indicated that Kuwaitis were higher in recognition of personal need compared to the other countries, however, 95% of Kuwaitis confirmed that in the presence of psychological problems they would refer to prayer, Kuwaitis tended to believe in more traditional healing compared to other participants, and only 25% of Kuwaitis stated they would seek professional help. While Kuwait is a country that has undergone significant economic modernization, there still exists a tremendous amount of traditionalism in their culture (El-Islam, 2000). Al-Krenawi et al., (2008) highlighted the influence of education around Kuwaiti students' receptiveness to psychotherapy suggesting that the higher the educational level, the greater the recognition of personal needs for psychotherapy. In support, Al-Rowaie's (2005) research found that Kuwaiti students' level of education determined their receptivity to psychotherapy, once again highlighting the positive impact of education on Kuwait's youth.

1.5 Relevance of the Present Study

This study aims to explore high school students' attitudes towards people suffering from mental illnesses in Kuwait, and investigate the impact of a brief educational intervention on their initial views. Additionally, the qualitative part of the study aims to explore beliefs and attitudes towards mental health of students in Kuwait and gain an in depth understanding of their personal experiences with mental health difficulties and discrimination.

While public attitudes towards mental health issues are under-investigated in the Middle-East (Al-Darmaki, 2003), a few studies have identified these beliefs as negative and rejecting (Al-Kernawi, 2005). These perceptions may serve as fundamental barriers to help-seeking behaviors in Arab adolescents as they attempt to conceal their illness and delay or deny treatment (Saxena, Thornicroft, Knapp & Whiteford, 2011). Considering the gap in the literature that has explored attitudes towards mental health and people suffering from mental health problems in the Arab culture, as well as the absence of such research in Kuwait, this study aims to focus on the following:

Quantitative Study - Research Aims:

1) Examine whether short-term interventions are useful in altering students' initial views towards mental health. More specifically, examine whether the interventions promote more accepting attitudes: increase in benevolence and a

decrease in social restrictiveness towards people suffering from mental illnesses.

2) Investigating the limitations of short-term/brief interventions in reducing stigma.

Qualitative Study - Research Aims:

1) Explore students' beliefs and attitudes towards mental health.

2) Gain an in-depth understanding of their thoughts around the presence of stigma as well as their personal experiences with mental health difficulties and discrimination.

1.6 Rationale for using Mixed Methods:

Gorard (2010) states: "No one, on buying a house refuses to visit the house, look at pictures of it, walk or drive around the neighborhood or talk to people about it. All rational actors putting a substantial personal investment in their own house would naturally and without any consideration of paradigms, epistemology, identity or mixed methods, use all and any convenient data to help make up their mind." (p.246)

This section aims to highlight the rationale for using a mixed methods approach. Burke Johnson and Onwuegbuzie (2004) defined mixed methods research as an approach where the researcher is able to mix and combine both quantitative and qualitative research techniques, approaches and methods into a single study. The combination of both research designs have the potential of providing the researcher with a deeper understanding of the phenomena where the findings answer a broader scope of questions. Moreover, the value of using a mixed methods design by collecting both quantitative and qualitative data neutralizes the weaknesses of each one of these approaches. Due to its multidisciplinary nature, mixed methods has gained popularity in the past decade and has been advocated by a number of researchers (Creswell & Clark, 2007). However, the field of counseling have been slow in adopting this paradigm due to a lack of understanding mixed methods research and its design strategies, the length of time it takes to conduct both quantitative and qualitative studies as well as a lack of knowledge on how to design, implement and analyze data in a mixed methods approach (Smith, 2012).

Quantitative research is often associated with the postpositivist worldview (Crotty, 1998). Researchers aim to test objective theories and examine relationships among variables. The data of this type of research is gathered in numerical form and analyzed using statistical procedures. This paradigm supports the claim that absolute truth can never be found and that knowledge is shaped by the data and evidence that is collected by the researcher (Phillips and Burbules, 2000). Moreover, the aim is to gather relevant data that serves to explain a certain situation or a causal relationship. They are considered to be more "problem oriented" than "process-oriented" (Wilson, Aronson, & Carlsmith, 2010). Quantitative purists believe that objectivity, elimination of biases and remaining emotionally detached from the objects of the study are the factors that contribute to reliable and valid social scientific outcomes (Nagel, 1986). However, this approach excludes the opportunity of conducting an in-depth analysis of the participant's personal experiences and gain a detailed understanding of the phenomenon of interest. Moreover, it disregards the participant's personal interpretations and meanings (Johnson, R. and Onwuegbuzie, 2004).

However, there have been changes in present quantitatively oriented studies in psychology. These changes are called "cognitive revolutions" (Ross, Lepper, & Ward, 2016, p.16). Modern day postpositivist scholars in psychology have provided a more comprehensive approach to research. They acknowledge the subjective role of both the participant and the researcher as well as cultural aspects and they stress

prediction over causation. Nevertheless, some psychological researchers remain dissatisfied with the postpositivist paradigm due to its heavy emphasis on hypothetico-deductive process of inquiry (McGrath & Johnson, 2003).

On the other hand, qualitative research adopts a constructivist paradigm and is characterized by an inductive exploration in the absence of theory. These studies are conducted in small samples and are concerned with the process and the context of behaviors (Tashakkori, Teddlie & Sines, 2012). Qualitative purists reject positivism and support constructivism, idealism, relativism, humanism, and hermeneutics (Lincoln & Guba, 2000). They believe that multiple realities exist, that it is impossible to fully differentiate causes and effects and the subjective knower is the only source of reality (Guba, 1990). "Observing, describing, and understanding became the key terms, and the new business was knowledge building and knowledge generation rather than affirmation or falsification of some previously established hypotheses" (Bamberger, 2003, p.ix-x). However, qualitative research is not immune to criticism. Some of the approach's limitations include the inability to generalize the knowledge that is produced, data collection and analysis is time consuming, and it may have less credibility due to its subjective nature and the researcher's personal biases.

The mixed methods design encourages researchers to use an eclectic approach to the way they conduct their research. It is considered to be an approach that is expansive, inclusive and pluralistic, therefore, mixed methods research adopts a pragmatic system of philosophy. This non-purist and more balanced approach

allows researchers to communicate and collaborate more efficiently (Maxcy, 2003). Quantitative and qualitative research have strengths and weaknesses. According to the "fundamental principle of mixed research" by Johnson and Turner (2003), the researcher is able to use their knowledge on these strengths and weaknesses to combine and mix strategies which then results in complementary strengths. Problems associated with singular methods can be reduced by adopting a mixed methods approach (Sechrest & Sindana, 1995). Mixed methods studies provide the researcher with the flexibility to use multiple data collection strategies as well as flexibility in the way that the data is analyzed.

The integrative approach of this mixed methods study is consonant with a pragmatic worldview. This approach prioritizes the research problem rather than the method, as well as the usage of several forms of data collection and analysis techniques in order to answer the research questions (Creswell, 2007). Thus, it provides the researcher with the flexibility to create a unique research design which prioritizes and focuses on the product of the research (Biesta, 2010). Pragmatism addresses the researchers' own values, epistemologies and world-views and the ways in which they impact actions and methodologies. Hence, this approach is similar to the humanistic approach in counselling psychology where clients are viewed as unique, and therapeutic approaches are tailored to fit their individual needs. Moreover, it allows the researcher to maintain a balance between the subjectivity in the reflexive process of the research and objectivity in data collection and analysis (Morgan, 2007).

This study contains two objectives, the quantitative phase aims to test an intervention and the qualitative phase aims to explore constructs that impact the researched phenomenon. Hence, Morgan (2007) suggests that pragmatism is useful for exploratory and intervention based studies similar to the current project. In addition, this framework assists the researcher in designing the study, examining a set of related constructs, and bringing together observations and facts from separate investigations in order to link findings from each study into an accessible and coherent structure (Polit & Beck, 2004). The pragmatic perspective emphasizes shared meaning-making which is created as a result of integrating results from each study. Pragmatism offers the researcher inter-subjectivity which emphasizes the disruption between complete objectivity and complete subjectivity (Morgan, 2007).

Creswell and Plano Clark (2007) emphasize the importance for the researcher to select a specific design to use in their studies. The latter provides the researcher with a framework and rationale that guides the research methods. The researcher must take several factors into consideration when choosing the specific mixed methods design. These include: the researcher's skills in using quantitative or qualitative designs, available resources, and most importantly, whether the design matches the research problem. Moreover, decisions must be made on the sequence or timing of data collection and analysis, the weighting or importance of each study, Morgan (1998) refers to the latter as "priority decision", and finally, the mixing decision, the way in which both data sets will be mixed.

This mixed methods study will adopt a convergent parallel mixed methods design (Creswell, 2014). Qualitative and quantitative data will be collected and analyzed concurrently but separately then brought together in the discussion phase to gain a more complete understanding of the research topic. The convergent parallel design allows the researcher to develop a more complete understanding of the research problem by obtaining different but complementary data. The researcher merges the results by discussing to what extent the data converge, diverge and relate to each other. The convergent parallel design is also referred to as triangulation (Bryman, 2006). The results of each study will be merged by identifying content areas represented in both data sets to compare and contrast results. During the first step the results of each study are compared in order to identify similarities, differences and apparent gaps. During the second phase the findings are interpreted in the discussion phase with the aim to synthesize complementary quantitative and qualitative results to develop a broader and more complete understanding of the phenomenon (Creswell, 2014). According to Creswell (2014), the parallel-databases variant is the approach used by researchers to examine different facets of a phenomenon using two types of data which are later synthesized and compared during the discussion phase. The qualitative and quantitative elements of this study are independent and do not rely on one another, they play a complimentary role to each other. Their aim is to gain a deeper and more extensive understanding of the constructs that influence stigma and the strategies to decrease stigma.

The survey in the quantitative part of this study aimed to explore adolescent's viewpoints on mental health and people suffering from mental illnesses. Participants were asked to fill out the survey before the informative talk and once again after the talk in order for the researcher to investigate the effect of the talks on the students' beliefs. Qualitative semi-structured interviews were also conducted in order to explore student's personal experiences with dealing with mental health difficulties and discrimination as well as get an in depth understanding on their views around mental health and people suffering from mental disorders.

The purpose of this experiment was to investigate whether more positive and accepting behaviors would emerge prior to the talk. The latter aimed to provide an in depth experiential understanding of the experience of dealing with mental health difficulties and the personal beliefs of the interviewee towards mental health in general and the stigma associated with it. Thus, the rationale for using a mixed methods design to produce a meaningful outlook on the personal beliefs towards mental health and the existing stigma associated with it.

Ethical approval was obtained from the research ethics committee at the University of Wolverhampton and confidentiality of participants' were ensured by adhering to the British Psychological Society's Code of Ethics and Conduct (BPS, 2009). There was no known risk to the participants taking part in the study. However, it was important to take into consideration that some of these students may have come across mental health issues in the past which could potentially stir up some

difficult emotions or memories. Therefore, the researcher provided students with a consent form and debrief sheet containing information on where they could seek help and they were notified of their right to withdraw from the study at any point before submitting the surveys since these were anonymous. The students taking part in the semi-structured interviews were able to withdraw from the study at any point.

CHAPTER 2:

QUANTITATIVE PHASE

QUANTITATIVE PHASE

2.1 Introduction

A 2-way mixed ANOVA was conducted for the quantitative phase of the study. The analysis of the data was performed using SPSS version 24. The researcher aimed to explore the effects of a brief educational intervention on the views of Arab adolescents towards mental health. Students were divided into two groups in order to assess differences in effect between the content of each intervention on adolescents' attitudes. The experimental group received a talk on 'Myths and Facts' around mental health while the control group received a more general talk around 'Education and Career' paths within the field of psychology. While past research demonstrated the positive impact of brief educational interventions on initial beliefs (Han & Weiss, 2005; Ojio et al., 2015; Santor & Bagnell, 2013), the aim was to gain a deeper understanding of which interventions had a higher impact in promoting more accepting attitudes.

Students attitudes were assessed in relation to two sub-themes 'Benevolence' and 'Social Restrictiveness' within the 'Community Attitudes Towards the Mentally Ill' questionnaire (Taylor & Dear, 1981). The exploratory nature of the study aimed to assess two contradictory attitudes: 'Benevolence' which is characterized by positive attitudes towards people suffering from mental disorders and 'Social Restrictiveness' which refers to the negative attitudes towards people with mental disorders. 'Benevolence' and 'Social Restrictiveness' are the two dependent variables of the study. While negative attitudes towards mental health are common (Pescosolido et

al., 2010), it is important to assess the presence of positive attitudes through the benevolence sub-scale in order to avoid solely investigating changes in negative attitudes. Therefore, the chosen dependent variables allowed the researcher to gain an in-depth evaluation and understanding of changes in attitudes both negatively and positively.

2.2 Methodology

2.2.1 Design:

The quantitative part of the study was based on a 2-way mixed design. Two independent variables were identified: 1) Control Group and Experimental Group (between groups, two levels) and 2) Time before and after the talks (within groups, two levels). The first independent variable consisted of two separate groups that received different talks. The first group (experimental group), received a talk on the different myths and facts around mental health and mental illness. The second group (control group), received a talk on the different educational and career paths one could chose from in the field of psychology. Moreover, two dependent variables were identified: 1) Benevolence subscale on the CAMI questionnaire and 2) Social Restrictiveness subscale on the CAMI questionnaire.

Before the study was conducted the students were given an information sheet which contained the details of participation, confidentiality and their rights to withdraw. However, once the surveys were submitted the participant would not be

able to withdraw since all surveys were anonymous and therefore unidentifiable. They were also asked to complete a background information sheet. Students were then asked to fill out the CAMI survey before the start of the presentations and once again right after the presentations with no delay between questionnaire completion and presentations. The aim was to investigate whether the talks had an effect on their opinions and whether the outcomes differed from one group to the other.

2.2.2 Participants:

A total of 105 participants took part in the experiment, 63.8% of the participants were males (n=67) and 36.2% were females (n=38). The participants were high school students attending the same private American School in Kuwait (American International School of Kuwait). Their ages varied from 14 to 18 years old. They were randomly assigned to the two groups based on their class schedules and availability. The high school counsellor aided the researcher in organizing the timetable for the research study to be conducted without interrupting the students' academic schedules. All the students that participated in the study were from an Arab ethnic group. Fifty-two students from grades 10 and 11 took part in the "Myths and Facts" talk. Fifty-three students from grades 9 and 11 took part in the "Education and Careers" talk. The classes were randomly assigned to either the 'Myths and Facts' group or the 'Education and Careers in Psychology' group.

According to the information presented by students on the background information sheet, 78 students (74.3%) reported having met someone suffering from a mental health disorder while 27 students (25.7%) reported that they never had contact with anyone with a mental illness. In addition, only 6 students (5.7%) had taken part in a psychology class in school while 99 students (94.3%) never attended a psychology class.

The researcher decided to chose this specific school for several reasons. In terms of conducting research, private schools are more accessible compared to public schools since decisions are directly in the hands of the school staff. Conducting research in public schools would require a lengthy and complicated process that would involve gaining permission from the ministry of education. Due to time limitations in conducting this study it was not possible to include public schools. Several private schools were approached and the American International School were the first to respond and show interest in the study and were highly accommodating and cooperative throughout the process. Therefore, the researcher decided to conduct the study in this school.

Nevertheless, students throughout all American private schools in Kuwait share very similar backgrounds. Demographic characteristics of students include coming from a middle-class or upper-class family that is able to afford the high cost tuition of attending a private school. On the other hand, students in public schools tend to come from lower class families with some exceptions where students from middle

class families and attend public schools due to Arabic being the main language. Kuwaitis attending public schools do not pay tuition, however students from other Arabic backgrounds pay a very minimal yearly fee.

The majority of students in private schools are Arabs that speak English as a second or first language both in public and at home with family. However, there is a fair number of international students attending the school. This study only included Arab students as it explored Arab adolescents' attitudes towards mental health. Questionnaires of international students were not included in the analysis. Most private schools in Kuwait have a counselor that provides students with educational support as well as emotional support when needed. Nevertheless, the counselor of this school stated that students rarely seek emotional support out of fear of being judged by their peers.

2.2.3 Materials:

Community Attitudes Toward the Mentally Ill Scale

'Community Attitudes Toward the Mental Ill' scale was created by Martin Taylor and Michael Dear (1981). This questionnaire will be referred to as the CAMI scale. The aim of this questionnaire is to measure public attitudes toward the mentally ill. The CAMI contains 40 items, 10 items in each of the 4 subscales of the questionnaire: Authoritarianism, Benevolence, Social Restrictiveness and Community

Mental Health Ideology. In this study only two of the subscales were used, thus a total of 20 questions were given to the participants:

1) Benevolence: which looked at factors such as the responsibility of society towards the mentally ill, their willingness to become more personally involved with those suffering from a mental illness and the need for more accepting attitudes from the public. High scores on this subscale indicate a positive view towards people with mental illnesses. Examples of statements included in this scale:

- The mentally ill have for too long been the subject of ridicule.
- We need to adopt a more tolerant attitude toward the mentally ill in our society.
- The mentally ill don't deserve our sympathy.
- It is best to avoid anyone who has mental problems.

2) Social Restrictiveness: this subscale explores the belief that people with mental illnesses are a threat to the community and that one must maintain a safe distance from them. High scores on this subscale indicate a fear towards the mentally ill. Examples of statements included in this scale:

- The mentally ill should not be given any responsibility.
- I would not want to live next door to someone who had been mentally ill.
- No one has the right to exclude the mentally ill from their neighborhood.
- The mentally ill are far less of a danger than most people suppose.

Participants reported their answers on a 5-point Likert scale ranging from 1 to 5: 1= strongly disagree, 2= disagree, 3= neither agree or disagree, 4= agree, 5= strongly agree. Based on a study conducted by Dear and Taylor (1979) which assessed 1,090 participant's attitudes towards the mentally ill using the CAMI questionnaire, the internal consistency of the survey's subscales were apparent: Benevolence α = .81 and Social Restrictiveness α = .80. For the data of the current study satisfactory alpha values were also reported for each subscale: Benevolence α = .80 and Social Restrictiveness α = .68. While the coefficient of social restrictiveness was lower it was still satisfactory.

The researcher decided to use only two of the four subscales of the CAMI for the following reasons:

1) the statements in the chosen scales fit best with the research study,

2) filling out the full CAMI survey would have been too time consuming as students were asked to fill out the survey twice, once before the talk and once after the talk.

2.2.4 Procedure:

The school counsellor gathered high school students to take part in the study based on their class schedules and availability. Students were briefly informed of the content of the presentations as well as their right to refuse participation or withdraw from the study. The talks took place in the school's library and were supervised by

the school counsellor, the librarian and a teacher. The researcher used a PowerPoint presentation for each talk.

Students were separated into two different groups:

Group 1 (Experimental Group): Students in this group received a 20-minute presentation about the different myths and facts around mental health and mental illnesses. The presentation was conducted in a pro-active way where the researcher put up statements on the projector such as "most people with mental illnesses are violent" and "biological factors are not the only causes of mental illness". Students were then asked to state their opinion on whether they thought the statement was a Myth or a Fact by a show of hands. The statement was then followed by an answer and an explanation of why it was either a Myth or a Fact.

Statements used in the presentation:

1) We only use 10% of our brain: MYTH.

2) Most people with mental illnesses do not need to be hospitalized: FACT.

3) All clinically depressed people suffer from extreme sadness: MYTH.

4) Most people with mental illnesses are violent: MYTH.

5) People without psychotic disorders could experience hallucinations while not on drugs: FACT.

6) Adults with schizophrenia or bipolar disorder are dangerous parents: MYTH.

7) Biological factors are not the only causes of mental illness: FACT.

8) People suffering from mental illness experience discrimination and inequality by the public: FACT.

9) You can easily tell when someone is mentally ill: MYTH.

Group 2 (Control Group): Students in this group received a 20-minute presentation about the different educational and career paths one could take within the field of psychology. The presentation focused on different bachelor and master degrees in psychology as well as the variety of different careers one could choose from such as counselling psychologist, sports psychologist, forensic psychologist, speech and language psychologist and others.

2.3 Results

2.3.1 Benevolence

1) First Main Effect - Groups:

A two-way mixed ANOVA was conducted to explore the main effect of students' responses in each group on the benevolence subscale. The between groups independent variable had two levels: Myths and Facts group and Education and Careers group. The repeated measures independent variable was time, also with two levels (before and after). The dependent variable was the Benevolence subscale of the CAMI questionnaire.

Table 1. Means and standard errors for the Group factor, with Benevolence as the dependent variable.

Group	Mean	Standard Error	Standard Deviation
Myths & Facts	40.77	0.56	4.08
Education & Career	38.46	0.57	4.00

As presented in table 1, differences in levels of benevolence between each group was statistically significant with the Myths and Facts group scoring higher on the benevolence subscale compared to the Education and Careers group: $F(1,103) = 8.46$, $p = .004$, partial $\eta^2 = .076$.

2) Second Main Effect: Time

The second main effect that was measured using a two-way mixed ANOVA was time (before and after). The analysis explored overall changes in responses of both groups combined on the benevolence subscale. The aim was to investigate whether students' responses altered following the talks.

Table 2. Means and standard errors for the Time factor, with Benevolence as the dependent variable.

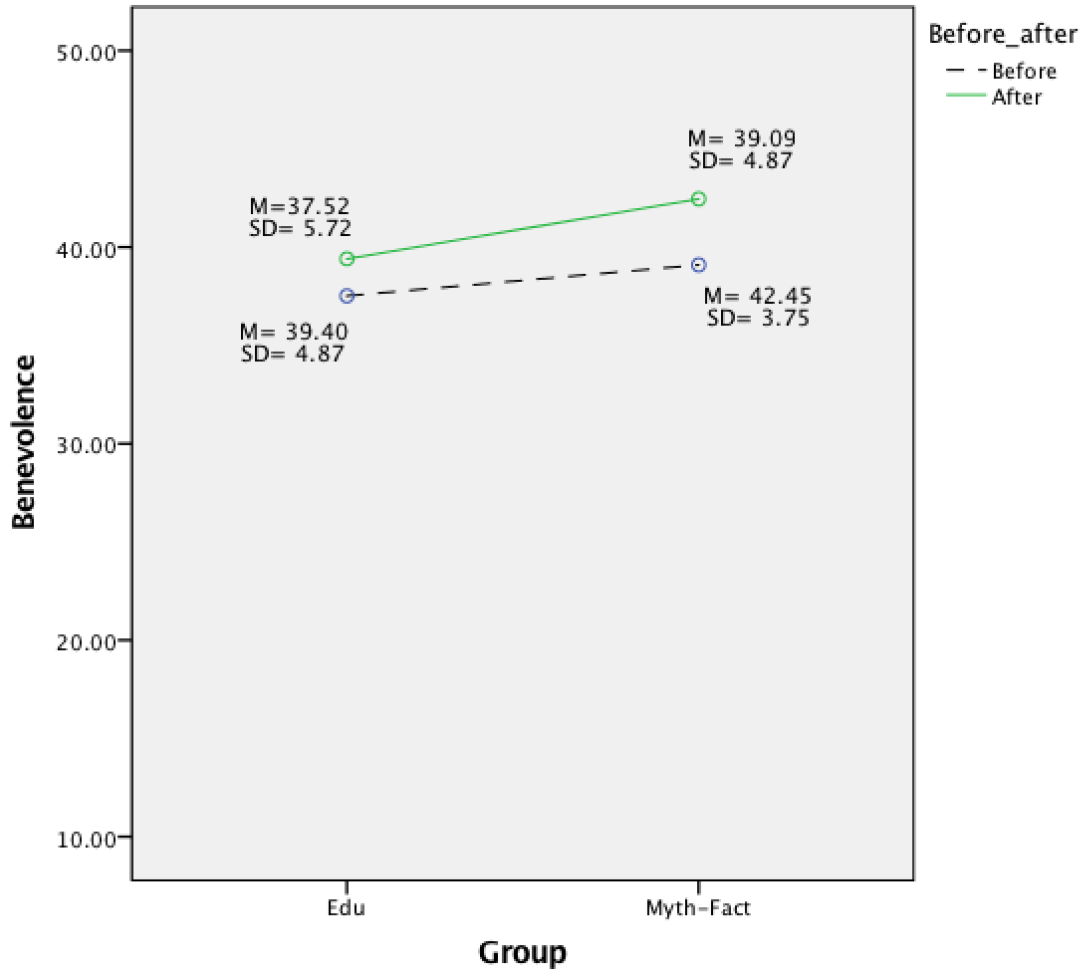
Time	Mean	Standard Error	Standard Deviation
Before	38.31	0.52	5.33
After	40.93	0.42	4.31

As presented in table 2, changes in responses on the benevolence subscale was highly significant overall, with students expressing more accepting attitudes following the talks. Benevolence scores were higher after the talks compared to before the talks were presented: $F(1,103) = 26.05$, $p < .001$, partial $\eta^2 = .20$.

3) Interaction between the Independent Variables (groups and time)

The analysis aimed to explore the interaction between the two independent variables: groups and times. As presented in Figure 1, the interaction between the groups and time is non-significant as both groups expressed higher benevolence after the talks compared to before the talks: $F(1,103) = 1.06$, $p = 1.54$, partial $\eta^2 = .02$.

Figure 1. Interaction between Groups and Time, with Benevolence as the dependent variable.



There was no significant difference between the effects of both talks as they both impacted students' responses and resulted in more accepting behaviors towards people suffering from mental illnesses.

2.3.2 Social Restrictiveness

1) First Main Effect: Groups

A two-way mixed ANOVA was conducted to explore the main effect of students' responses in each group on the Social Restrictiveness subscale. The group independent variable had two levels: Myths and Facts group and Education and Careers group. The repeated measures independent variable was time, again with two levels (before and after). The dependent variable was the Social Restrictiveness subscale of the CAMI questionnaire.

Table 3. Means and standard errors for the Group factor, with Social Restrictiveness as the dependent variable.

Group	Mean	Standard Error	Standard Deviation
Myths & Facts	20.43	0.51	3.71
Education & Career	22.98	0.51	3.68

As presented in table 3, differences in levels of social restrictiveness between each group was statistically significant with the Education and Careers group scoring higher on the social restrictiveness subscale overall compared to the Myths and Facts group: $F(1,103) = 12.61$, $p = .001$, partial $\eta^2 = .11$.

2) Second Main Effect: Time

The second main effect that was measured using a two-way mixed ANOVA was time (before and after). The analysis explored overall changes in responses of

both groups combined on the social restrictiveness subscale. The aim was to investigate whether students' responses altered following the talks.

Table 4. Means and standard errors for the Time factor, with Social Restrictiveness as the dependent variable.

Time	Mean	Standard Error	Standard Deviation
Before	23.22	0.46	4.72
After	20.19	0.45	4.61

As presented in table 4, changes in responses on the social restrictiveness subscale was significant overall: $F(1,103) = 28.93$, $p < .001$, partial $\eta^2 = .22$. Scores on the social restrictiveness subscale were higher before the talks. Social restrictiveness scores went down post-intervention compared to pre-intervention which suggests that the talks promoted more accepting attitudes towards people with mental illness.

3) Interactions between the two independent variables (groups and times)

The analysis aimed to explore the interaction between the two independent variables: groups and times. As presented in Figure 2, the interaction between the groups and times is significant: $F(1,103) = 16.65$, $p < .001$, partial $\eta^2 = .14$. Social restrictiveness scores decrease significantly in the Myths and Facts group following the intervention, but do not decrease in the education group. The results suggest that students adopt more accepting attitudes and less social restrictiveness towards people with mental disorders following the Myths and Facts talk.

Figure 2. Interaction between Groups and Time, with Social Restrictiveness as the dependent variable.

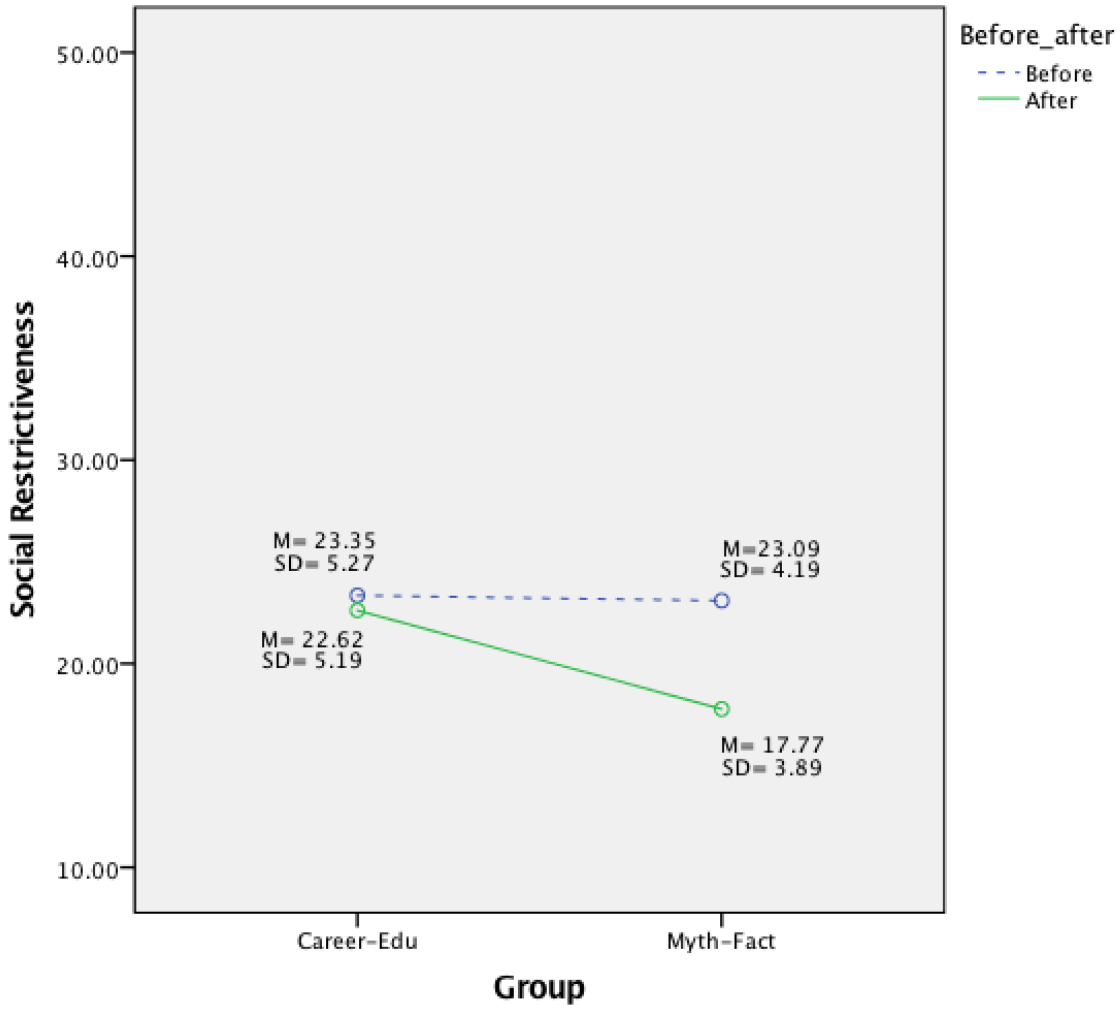


Figure 2 shows that the two groups react quite differently to each intervention. The Myths and Facts talk appears to have had an effect on the students' responses compared to the Education and Careers talk.

2.3.3 *Simple Effects Analysis: Social Restrictiveness*

A simple effects analysis was conducted as a follow up analysis to the above interaction (Figure 2). There is a significant difference between before and after responses on the social restrictiveness scale for the Myths and Facts group: $F(1,52) = 38.00$, $p < .001$, partial $\eta^2 = .42$.

However, there was no significant difference between before and after responses on the social restrictiveness subscale for the Education and Careers group: $F(1,51) = 1.04$, $p = .314$, partial $\eta^2 = .02$.

2.4 Summary of Findings

The findings of the quantitative study support previous research that investigated and reported the benefits of brief educational interventions on students' initial views towards people suffering from mental illness (Arboleda-Florez & Sartorius, 2008; Ojio et al., 2015; Schachter et al., 2008; Wei et al., 2013). The results demonstrated significant changes in the first dependent variable (levels of benevolence) following the interventions. Students in the experimental group and the control group displayed higher levels of acceptance post-intervention. Nevertheless, it appeared that students in the experimental group displayed higher levels of acceptance overall compared to the control group. These results may suggest that the content of the 'Myths and Facts' group had a greater impact on attitude alteration following the talk.

While the interventions significantly impacted the first dependent variable (benevolence), this was not the case for the second dependent variable (social

restrictiveness). Participants in the control group displayed higher levels of social restrictiveness overall compared to the experimental group. Moreover, while social restrictiveness scores decreased significantly in the experimental group, they remained unaltered in the control group following the interventions. The results may suggest that the content of the talk given to the control group did not have similar effects as the experimental group.

Given the results of each of the dependent variables, it is possible to suggest that positive attitudes (benevolence) are more easily reinforced while negative attitudes (social restrictiveness) are harder to alter. Therefore, it is important to consider the content of the interventions when altering negative views towards mental health. Educating the youth on general information about educational and career paths in psychology may strengthen levels of benevolence, however, it is not sufficient to decrease negative attitudes. The results of the study highlight the importance of carefully choosing the content of the talks when educating the youth on mental health.

The findings support the researcher's predictions around the benefits of directly teaching the youth about mental illness and challenging false beliefs. Similarly, Yamaguchi, Mino and Uddin's (2011) narrative review of educational interventions examined forty eligible studies and identified a need to eliminate incorrect beliefs around the dangerousness of people with mental illness in order to yield significant changes in attitudes when educating the youth.

The current study demonstrated immediate improvements in young people's attitudes, however, there was no follow-up study to assess the long-term effects of the intervention. Previous studies assessing educational interventions that had a post-test and a long-term follow up reported a decrease in the effects of the intervention in the long-term follow up compared to the post-test (Chan, Mak & Law, 2009; Finkelstein, Lapshin & Wasserman, 2007; Finkelstein, Lapshin & Wasserman, 2008; Pinfold, Toulmin, Thornicroft, Huxley, Farmer & Graham, 2003; Roberts, Somers & Dawe, 2007). In addition, while attitudes were altered following the talks, behavioral changes were not assessed. Yamaguchi et al. (2011) suggest that behavioral changes are difficult to assess during short studies. Moreover, they argue that changes in behavior take longer to occur compared to changes in knowledge and attitudes.

Lastly, it is possible to suggest that social desirability bias may have impacted students' responses as they attempt to appear more accepting with their answers in order to please the researcher and the public (Grimm, 2010). Nevertheless, if this were the case, changes in attitudes would have occurred in both groups. However, the results demonstrate significant changes in levels of social restrictiveness in the experimental group (myths and facts group) but not in the control group (educational group). The results of this study are discussed in more depth in the overall discussion chapter.

CHAPTER 3:

QUALITATIVE PHASE

QUALITATIVE PHASE

3.1 Introduction

The qualitative component of the mixed methodology aimed to gain an in-depth understanding of participants' views towards people suffering from mental illnesses. Moreover, the researcher attempted to explore participants' personal experiences in dealing with mental health difficulties and discrimination as well as their understanding around mental illness stigma. Qualitative methods are appropriate when there is a lack of research in a certain area as it brings to the fore novel and unpredicted knowledge (Creswell, 1998; Ponterotto, 2002). Stigmatizing attitudes around mental health issues are under-investigated in the Middle-East (Al-Darmaki, 2003), and non-existent in Kuwait (Hickey et al., 2016). Therefore, for the qualitative phase of the research, semi-structured interviews were analyzed using a thematic approach as outlined by Braun & Clarke (2006) in order to fit the exploratory nature of the study.

Previous attempts to decrease stigmatizing attitudes focused mostly on adults' views towards individuals suffering from mental disorders thus informing strategies to tackle stigma within this group specifically. However, past research suggested that adolescents had more stigmatizing attitudes compared to adults (Einsberg et al., 2009; Yap & Jorm, 2011). Therefore, of particular interest were the views of Arab adolescents towards those suffering from mental illnesses. This is especially important since research on Arab adolescents' views towards mental illness is sparse.

By gaining a deeper understanding of their beliefs, their experiences, and the ways in which culture and religion impact such attitudes, future research may focus on specific strategies to reduce stigma within this population.

3.2 Methodology

3.2.1 Rationale for Using Thematic Analysis

Holloway and Todres (2003) describe qualitative approaches as incredibly diverse, complex and nuanced. Specifically, thematic analysis is used "for identifying, analyzing and reporting patterns within data" (Braun & Clarke, 2006, p.79). According to Blacker (2009) a rich thematic description provides an indication of "the predominant and important themes" (p.83). Hence, the present study aims to identify salient themes and recurring patterns around beliefs, attitudes, opinions and experiences of Arab adolescents in relation to mental illness and stigma. The process of analysis in a thematic approach goes beyond the mere act of describing themes as it aims to interpret the significance of identified themes in terms of their broader meanings and implications (Patton, 1990). The process of interpretation relies on the participants' reflective abilities as well as their capacity to verbalize their opinions (Mackenzie & Knipe, 2006). Moreover, it is important to recognize the active role of the researcher and the ways in which they form and interpret knowledge.

A thematic approach allowed the researcher to gain in-depth knowledge around participants' personal experiences, beliefs and opinions (Tariq & Woodman, 2010; Teddlie & Tashakkori, 2009) whilst encouraging them to relay their views using their own words (Strudwick & Morris, 2010). Braun and Clarke (2006) highlight the importance for the researcher to clarify their analytic and epistemological stance (Holloway & Todres, 2003). In the current research a constructionist method was adopted. The latter examines the ways in which realities, meanings and experiences are the outcomes of a range of societal discourses and acknowledges and emphasizes the individual's experiences and the existence of multiple realities (Braun & Clarke, 2006). The chosen paradigm was appropriate for the current research as it aimed to gain multiple perspectives regarding views around mental illness as well as factors contributing to stigmatizing attitudes within the Arab population. Additionally, the present study's overall focus revolved around public stigma and shared negative attitudes, hence, the constructionist perspective was adopted since it suggests that meanings and experiences are socially produced (Burr, 1995).

Moreover, an inductive approach to understanding subjective human experiences was assumed due to the lack of such investigations in the Middle-East, thus, making it a relatively new area of research. This form of approach suggests that the themes identified are strongly linked to the data themselves (Patton, 1990). Therefore, the researcher does not form hypotheses around expected outcomes. In accordance, themes were identified at a semantic level, thus supporting the aim to

identify themes within the explicit or surface meanings of the data (Braun & Clarke, 2006).

While thematic analysis is often viewed as a tool rather than a specific method (Boyatzis, 1998), Braun and Clarke (2006) argue that it should be considered a method in its own right. The flexibility of the approach provides researchers with a useful tool to provide a rich and detailed yet complex account of the data (Braun & Clarke, 2006). Conversely, some scholars criticize the flexibility of qualitative research due to the absence of clear and concise guidelines (Laubschagne, 2003). However, conducting qualitative research requires rigorous methods of analysis in terms of data collection and data analysis (Braun & Clarke, 2006).

3.2.2 Rationale for using Semi-Structured Interviews

The analytic process of the present study followed Braun and Clarke's (2006) six-phase outline of thematic analysis. Semi-structured interviews reflect counselling psychologists' natural form of interviewing in sessions with their clients (Chenail, 1997). The usage of such an approach allows the researcher to identify predetermined themes whilst searching for new and unexpected topics. Robson (2002) defines semi-structured interviews as "predetermined questions, but the order can be modified based upon the interviewer's perception of what seems appropriate" (p.270). Moreover, open-ended questions bring insight into areas that are under-conceptualized and under-researched (Robson, 2002) as well as promote a space

that facilitates open communication between the researcher and the participant, similar to a therapeutic setting.

The interviewing process is based on a set of questions which the researcher has flexibility to expand on (Mitchell & Jolley, 2007). Semi-structured interviews enable the researcher to follow the participant's lead, however, in order to ensure that relevant knowledge is gained in relation to the research question, some structure is required. Therefore, a set of questions were established by the researcher in order to guide the interview, nevertheless, the approach involved a certain level of flexibility in exploring other relevant areas that surfaced.

Lastly, the researchers' reflexive process allows them to acknowledge their influence on the procedure (Thorpe, 2013). Diefenbach (2009) states that "science in general is a human endeavor and one cannot have ideas, assumptions, theories, and formulas without the human factor" (p.876). Thus, highlighting the influence of the researchers' own biases and subjectivity. The humane nature of conducting qualitative research complements the similar ethos of counselling psychology and could be considered a strength. Yeh & Inman (2007) also emphasized the importance of acknowledging the researcher as a crucial part of the process as they are viewed as being "inextricably linked" (p.371).

3.2.3 Consideration of Other Methods

A crucial part of the research process is the selection of an appropriate approach that fits best with the study aims. Different aspects of qualitative methods may overlap (Holloway & Todres, 2003), therefore, other approaches were considered. Due to the many similarities between Thematic Analysis and Interpretative Phenomenological Analysis (IPA) (Guest, MacQueen & Namey 2012), both approaches were explored. Similarities between the approaches include drawing out themes from the data and making sense of people's lived experiences (Collins & Nicolson, 2002; Huxley, Clarke & Halliwell, 2011). However, the differences between both approaches led the researcher to select thematic analysis as the appropriate approach for this study. According to Smith, Flowers and Larkin (2009) IPA attempts to find meaning beyond what the participant presents during the interview, and reveal information about the participant that they may not be aware of themselves, thus, IPA aims to reveal latent meanings. However, the present study aims to draw themes based on what is being presented by the participant, therefore, thematic analysis was considered the most appropriate approach given the research aims of the study.

3.2.4 Participants and Procedure

For this phase of the study a total of 6 high school students were interviewed. The 6 participants attended the same school as the students in the quantitative study, however, they did not take part in the intervention phase of the research. Interviews were conducted right after the quantitative study during the

same summer. Students were recruited using a snowball sampling method: participants were encouraged by the researcher and school counselor to refer peers that were interested in taking part in the study. Students that wished to participate contacted the researcher electronically or by telephone in order to schedule a meeting. The location and time of the interviews were organized based on participants' availabilities and convenience. Some interviews were conducted at the school in an empty classroom while others were conducted in a therapy room at the researcher's workplace.

A total of 6 students took part in the qualitative study with the flexibility of conducting further interviews if the data did not provide sufficient relevant information. Sufficiency of data was ensured through data saturation (Fusch & Ness, 2015). This view of saturation, also labeled 'informational redundancy' by Sandelowski (2008), considers how much data or interviews are needed until nothing new is apparent. During data transcription the researcher created a list of initial codes for each interview and commonalities and differences between each interview were highlighted. According to Saunders et al. (2017), saturation is seen as separate from, and preceding the analysis stage and therefore can be identified at an early stage of the process. Further data collection was deemed unnecessary following the six interviews since a significant amount of relevant and common themes were identified through the initial phase of coding.

Demographic Information of Participants

Participants	Age	Gender	Ethnicity	Psychology Class Attendance	Contact with a person with a mental disorder
Student 1	18	Female	Arab	No	Yes
Student 2	18	Male	Arab	No	No
Student 3	18	Female	Arab	Yes	Yes
Student 4	18	Female	Arab	Yes	Yes
Student 5	16	Male	Arab	No	Yes
Student 6	16	Female	Arab	No	Yes

3.2.5 Data Analysis

The aim of the qualitative study is to provide a more comprehensive account of the research question. Semi-structured interviews were analyzed using a thematic analysis approach as outlined by Braun and Clarke (2006). The interview was guided by a list of 11 questions compiled by the researcher. The questions provided the interview with a sense of structure, however, flexibility was an important component of the process in order to allow new and unanticipated knowledge to emerge. Interviews lasted between 35 minutes to an hour. Themes were identified using an inductive approach, nevertheless, theoretical understandings of mental illness stigma as outlined in the literature review informed the process of analysis to some extent. For instance, questions around the impact of religion and culture on stigma were added based on the literature.

Interviews were recorded onto a telephone containing a security code and deleted once they were uploaded onto the computer and transcribed by the researcher. The format of transcription was based on a revised version of Silverman's syntax of conversation analysis as adapted by Gubrium & Holstein (2002). Interviews were analyzed using Braun and Clarke's (2006) six phase model:

Phase 1*:* The researcher transcribed the data and noted initial ideas while transcribing. The researcher further familiarized themselves with the data by reading and re-reading the interviews whilst paying particular attention to re-occurring patterns as well as the discovery of new themes and ideas.

Phase 2: The researcher generated initial codes based on relevant themes across the entire data set. Important and interesting data were coded systematically. Interviews were printed and coded manually.

Phase 3: Important themes were noted down and relevant codes were collated into these potential themes. Major and minor themes were noted on separate papers to differentiate between their relevance in order to avoid excluding themes that were less important and potentially use them as sub-themes.

Phase 4: During this phase thematic maps were generated. Themes were checked and reviewed in order to highlight the more relevant ones. Re-reading and re-visiting the entire data set was important to ensure that significant data

was not overlooked. A clearer version of potential main themes was developed.

Phase 5: Themes were defined and named. The specifics of each theme were refined to provide a clear understanding of their role and definitions.

Phase 6: This phase constituted the production of the report. A refined thematic map was developed and a final selection of relevant extracts was checked in relation to the research aims.

The initial coding process was done manually by the researcher during transcription. The researcher created a list of initial codes for each interview by highlighting as many relevant topics presented by the participant in the form of bullet points. Initial codes were compared and commonalities between interviews were noted down. Later, a more in-depth process of coding was conducted manually by the researcher using post-it notes on the transcribed interviews, highlighters to emphasize relevant extracts from the interviews and additional notes were taken on every page of the interviews. The codes from each interview were compared and combined in order to inform the process of searching for themes. A number of potential themes were noted down which formed the first thematic map of initial themes (appendix O). At the end of this stage a list of potential themes and sub-themes were listed. Themes were included based on their relevance to the research topic as well as their repetition throughout the interviews. Themes were included if they were emphasized by a number of participants and were also related to previous literature on the topic. Initial coding on transcripts are available in the appendices.

3.2.6 Trustworthiness and Credibility of Analysis

Lincoln and Guba (1985) state that credibility of a study can be initiated through a number of techniques such as triangulation, peer debriefing and member checking in order to check preliminary findings and interpretations against raw data. Credibility is enhanced if the data are analyzed by more than one researcher (Cote & Turgeon, 2005; Lincoln & Guba, 1985). Preliminary codes and themes were examined by the researcher's supervisors in order to identify and resolve any anomalies and were checked by the supervisor throughout the process. Moreover, to ensure reliability, themes were checked against the transcript throughout the process (Strudwick & Morris, 2010).

Hierarchical coding was conducted and allowed the researcher to analyze the text at different levels of specificity (King, 2004). This process includes broad higher order codes (providing an overview), and lower order codes (which allow for distinctions to be made between and within interviews). Different levels of coding were conducted by the researcher: codes were listed for each interview separately during the transcription phase and were later compared and combined in order to inform the in-depth coding process that was conducted directly on transcripts (appendix S). An initial thematic map was created manually and included initial themes and sub-themes derived from the coding process. Moreover, triangulation or data saturation was used in order to ensure sufficient relevant data was collected by the researcher, thus, data is gathered to the point of redundancy (Lincoln & Guba,

1985). Records of raw data, field notes, transcripts and coding facilitate the reporting of the research process and allow the researcher to create a clear audit trail (Halpren, 1983). The researcher included such evidence in the appendices (appendix S), documents included: preliminary coding, coding on transcripts, notes around initial codes, and initial thematic map.

According to Savage (2000), the coding process in qualitative data is a process of reflection and interaction with the data. Reflexive journaling allows the researcher to establish an audit trail in order to keep track of the steps taken in the process of analysis (Cutcliffe & McKenna, 1999; Morse & Richards, 2002). Reflexivity of the researcher was maintained throughout the procedure with a particular awareness around the impact of personal biases. A self-reflective journal which informed the write up phase of the 'critical appraisal' chapter contained a record of notes on the researcher's experiences throughout the research project. Reflexivity was also maintained during supervision sessions. Morrow and Smith (2000) state that reflexive strategies include consulting with other researchers who serve as a mirror that reflect the responses to the research process. Moreover, findings were discussed with other colleagues in order to engage in a "critical and sustained discussion" (Rallis, 2003, p.69). The data was re-visited several times during the write up phase to ensure that the chosen themes remained relevant.

3.2.7 Ethical Approval

Ethical approval was obtained from the Ethics Committee at the University of Wolverhampton and confidentiality of participants was ensured by adhering to the British Psychological Society's Code of Ethics and Conduct (BPS, 2009). Students who took part in the interviews were provided with a consent form and debrief sheet and were advised that their participation was voluntary and that they were free to withdraw at any time. There was no known risk to the participants taking part in the study, however, some of these students may have come across mental health difficulties in the past which may potentially arouse some difficult emotions or memories. Therefore, students were provided with a sheet containing information and resources on where they could seek help and support if needed.

3.3 Results and Discussion

During the initial analysis of the data a total of five main themes were noted and included 36 sub-themes. Through the process of refining the concepts, three main themes were chosen in addition to 12 sub-themes:

Theme 1: Students' Beliefs Towards Mental Illness

1.1 Lack of knowledge

1.2 Treated unfairly

1.3 Acceptance with conditions

1.4 Benefits of support and therapy

Theme 2: Students' Thoughts on the Public's Views Towards Mental Illness

2.1 "Less than"/ incompetent

2.2 Burden

2.3 Shameful

2.4 Fearful: dangerous and unpredictable

Theme 3: Causes of Stigma

3.1 Media

3.2 Lack of knowledge/ ignorance

3.3 Culture and religion

3.4 Approaches to decrease stigma

The final themes and sub-themes reflect the research aims to explore views of adolescents towards mental illness and gain a deeper understanding of key factors that may influence public stigma within the Arab population. Extracts from the interviews will be presented within quotation marks throughout the analysis and students will be referenced using a number in order to maintain confidentiality (e.g. Student 1, Student 2). Fine (2002) describes the process of extracting items from the data set as "carving out unacknowledged pieces of narrative evidence that we select, edit, and deploy to border our arguments" (p. 218).

This section will combine both the results and discussion sections of the study by contextualizing the data with relevant literature in order to highlight the interpretative value of the analysis (Braun & Clarke, 2013).

Theme 1: Student's Beliefs Towards Mental Illness

This first theme, including its sub-themes, highlights the students' beliefs towards mental illness as well as their experiences in dealing with mental health difficulties or supporting someone with a mental disorder. While previous research focused on adolescents' beliefs and attitudes in western countries, very little research

investigated Arab adolescents' views (Hickey et al., 2016). An emphasis is placed on familiarizing oneself with existing views within a specific population in order to inform strategies and approaches to decrease mental illness stigma and encourage more accepting attitudes. Investigating such beliefs is the first step towards promoting change, thus, the importance of exploring the matter in a country such as Kuwait where research on the issue is inexistent (Almazeedi & Alsuwaidan, 2014).

1.1 Lack of knowledge

A number of participants expressed the lack of knowledge they had around mental illnesses: *"What is this? How could someone be feeling so upset all the time?... I would go to my mother and I'd be like 'How does this work? How does this happen?'" (Student 1); "I never actually learned about mental health" (Student 2)*.

Moreover, some students described their first contact with someone with a mental illness as confusing since they lacked the knowledge to comprehend the issue in hand and how to provide support: *"My cousin's autistic and he's six years old but before he was born the only way I ever really knew autism or any mental illness was through movies or videos on Instagram... But before that I never really could understand mental illnesses, and to be honest I was actually scared of people that had mental illnesses" (Student 6); "I was so confused at the time" (Student 3); "Up to the point where I met her I didn't really know how to talk with somebody who had*

depression...you feel so incompetent when it comes to helping her with her issues...you don't understand the basics of it" (Student 4).

Education and knowledge have been shown to predict more accepting behaviors (Ikwuka et al., 2016), nevertheless, the majority of participants had no previous awareness around mental disorders. This analysis appears to be consistent with previous research that suggests that the youth are an important target for raising awareness and knowledge (Amminger et al., 2006; Oakley et al., 2006). Additionally, research has found that younger students have more stigmatizing attitudes compared to adults (Yap & Jorm, 2011). The students' unfamiliarity with mental illnesses inhibited their ability to understand the individual's situation and provide support. This potentially may impede their capacity to recognize their own mental health needs and seek support when required, especially given that the onset of various mental illnesses and difficulties arise during adolescence (Amminger et al., 2006): *"I felt alone and I believe I was depressed, I don't know if I was or not" (Student 3).*

1.2 Treated unfairly

All of the participants believed that they would be treated unfairly by the public if they were diagnosed with a mental disorder: *"I feel like I wouldn't be treated fairly because I know I wouldn't treat someone with a mental disorder fairly" (Student 1); "I think the biggest problem is that people would be moving away" (Student 2); "If I*

don't mention it then they would treat me fairly, but once they know, I don't think they would", "They have so many opportunities taken away from them" (Student 6). It appeared that the students attached the concept of mental illness with rejection and a sense of not belonging or fitting in with society.

One of the students in particular has a diagnosis and out of fear of being judged and treated differently, he decided to keep his diagnosis a secret between himself and his mother *"I would be blamed; I think people will disconnect from me...it's negative because it's kind of like keeping a part of yourself a secret" (Student 5).* The discrimination and stigma experienced by adolescents impacts their help-seeking behaviors (Bowers et al., 2013), and their ability to achieve their academic goals (Hinshaw, 2005): *"I was a gifted child as a kid so after what happened to me my grades dropped" (Student 5).*

The negative outcomes of mental illness stigma have been highlighted in several studies, for instance, people with mental illnesses are less likely to be hired (Bordieri & Drehmer, 1986; Farina & Felner, 1973): *"I wouldn't want to be in a workplace that wouldn't accept me for who I am" (Student 3), Researcher: "And do you think some people might not hire you because of that?" Student 3: "Definitely"; "They'd see you as a lesser candidate, you're not as capable for the position as someone that doesn't have a mental illness" (Student 1).* The majority of participants predicted unfair treatment in several areas of their lives, such as school, workplace and relationships, if their diagnosis was to be publicized. These expectations may

predict help seeking behaviors in adolescents, who are less likely to access mental health services due to stigma (Biddle et al., 2004). In addition, experiencing stigma and discrimination from the public may result in a decrease in self-efficacy and self-esteem (Corrigan et al., 2006), which may hinder their enthusiasm and motivation to set goals and achieve them.

1.3 Acceptance with conditions

Participants expected negative reactions from the public towards an individual with a mental illness. Nevertheless, when they were asked about their own opinions they expressed a high level of acceptance and understanding towards people with mental disorders: *"I look at the person, I don't look at whether they have a mental issue" (Student 2); "I would literally be with them 24/7 trying to understand" (Student 3); "I think they are just like everybody else", "I'll be there to help you through it no matter what" (Student 4); "The person is still the same, it's just they're going through something" (Student 5).*

Additionally, when students were asked whether they would marry or hire someone with a mental illness all participants responded positively: *"I feel like I would hire the person with schizophrenia just because 'I want to take you; you probably want this more than he does'" (Student 1) "I would hire them definitely" (Student 3).*

Nevertheless, the majority of positive responses came with conditions: *"If I can be normal with the person if I can have a proper conversation", "I would because they are stable on the medication" (Student 2); "I would definitely not say no... If it were too hard and then it started affecting me then I would have to be selfish and be able to say I can't handle it" (Student 1); "I would hire that person. I think one part of it though I would have weekly check-ins, not to degrade them, just to check" (Student 4); "The only thing I would do is get a background check" (Student 5); "If I can talk to them, help them and I can understand them then it's fine with me" (Student 6).* The analysis may possibly suggest that students may have wanted to appear more accepting with their responses or please the researcher rather than provide answers that are reflective of their actual feelings: social desirability bias (Grimm, 2010).

In accordance to the theory of planned behavior (Ajzen, 1991), and based on the conditions presented by the students in the interviews, the positive attitudes presented by the participants did not predict positive behavior. Similarly, studies that explored changes in adolescents' attitudes through educational interventions suggested that changes in attitudes did not reliably predict behavior (Chung & Chan, 2004; Herbert et al., 2000). It appeared that despite their willingness to support and accept individuals with mental illness, a level of hesitation emerged when faced with real life decisions to interact with someone with a mental disorder.

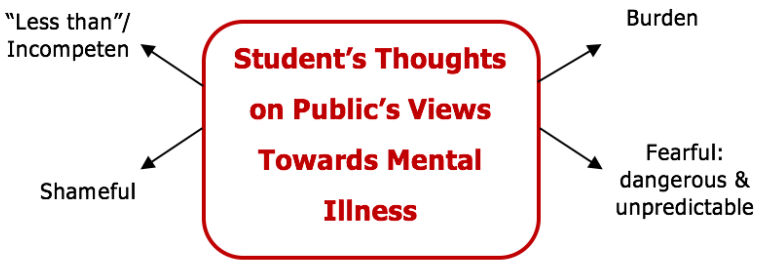
1.4 Benefits of support and therapy

Family and social support as well as therapy were identified as crucial factors that promote well-being and aid the individual to overcome mental health difficulties. As a collectivist society, supporting one another is considered a responsibility: *"In my family if someone were to be diagnosed we'll all get together and be like okay now it's literally on our sleeve, how old or how young, you are a part of this and you're taking responsibility" (Student 1); "All my family at the moment are supporting her 100%" (Student 3).* The participants highlighted the importance of seeking support from their surroundings: *"You need a supportive family or people around you to support you" (Student 6)*; however, they also appeared to be hesitant and fearful about revealing their mental health difficulties; even to their closest friends and family members: *"It's not easy to approach someone and talk to them about it, so I find it better for myself to just keep quiet" (Student 2); "I think there would be times I would regret it just because there's a look in people's eyes when they know somebody has a mental illness" (Student 4); "It's hard because you can't really share everything with your family especially your mental illnesses" (Student 5).*

Students that had direct or indirect experiences with therapy recommended therapeutic support and were able to identify its' benefits: *"First thing, therapy is very helpful, so I would try to get them to therapy", "It helped a lot when I had no one to talk to" (Student 5); "But after we took him to therapy and now he's normal" (Student 6).* Al-Rowaie (2005) studied Kuwaiti students' receptivity to psychotherapy and suggested that the latter was determined by their level of education.

Nevertheless, a study conducted by Al-Krenawi et al. (2008) found that only 25% of Kuwaiti students would seek professional help. It is possible to suggest that direct or indirect contact with therapy along with education would promote higher levels of help-seeking behaviors amongst Arab adolescents. The analysis displayed positive attitudes towards seeking professional help and support, nonetheless, previous research indicated that Arab adolescents are often reluctant to seek treatment out of fear of bringing shame to one's family or being perceived as weak (Al-Darmaki, 2003; Hijawi et al., 2013). Thus, while participants may encourage help-seeking behaviors, the actual act of seeking support is not guaranteed.

Theme 2: Student's Thoughts on the Public's Views Towards Mental Illness



The second theme appeared essential in understanding the Arab society's views towards mental illness from the participants' perspectives. According to Rao et al. (2007), the concepts of mental illness and mental illness stigma are deeply tied to culture, thus, they vary across cultures. The analysis provided the researcher with insight on shared beliefs within the community and the ways in which such beliefs are passed down from one generation to the other.

2.1 "Less than"/ Incompetent

A common belief shared between participants was that individuals with mental disorders or mental health difficulties are viewed by the public as incompetent and "less than" somebody without a disorder: *"They think they're better than everyone else, so they can't be seen with somebody who is less than what they see themselves", "They just don't think of them as equal" (Student 2); "They don't think they are in their right mind and their mind isn't functioning properly" (Student 3); "You know how you talk down to a kid? They're basically talked down to" (Student 5); "They think 'oh he doesn't understand, he's not a normal human being", (Student 6).* The concept of incompetence is a common stereotype used to describe people with mental disorders (Atilola & Olayiwola, 2011). This is due to the belief that mental disorders signify a presence of abnormalities in cognitive processing, thus, leading to the idea that individuals with mental illnesses are unable to perform as well as someone without a disorder. Participants perceived the link between inadequacy and mental illness as debilitating and harmful and expressed the need for the public to treat everyone equally: *"It annoys me because there's no difference between us" (Student 5); "They'll start treating me differently and they'll think I'm not as capable of doing stuff...They won't think I'm capable of performing" (Student 6).*

2.2 Shameful

The association between shame and mental illness within the Arab population is not uncommon. Many adolescents are reluctant to seek help due to the fear of bringing shame to the family (Sayed, 2002), and "associative stigma" refers to the shame associated with a family member's diagnosis in the Arabian Gulf countries such as Kuwait (El-Islam, 1994). The analysis further confirmed these beliefs: *"They're ashamed of that person so they just put them in a room", "In some cases it's like 'I gave birth to this' or 'I'm related to this' so it's like 'I don't want to have to be thought of as the person with an autistic bother'" (Student 1); "Some people would be embarrassed" (Student 2); "It's an embarrassment or it's a disgrace to the family or it's a disgrace to how the parent's raised the kids" (Student 3); "It's shameful for a lot of people" (Student 5); "because their daughter/son isn't normal, they feel like they're not proud and they can't show them off" (Student 6).*

An emphasis is placed on public image and the need to fit in, therefore, anything that stands out is considered shameful. In this case students acknowledged that the public viewed a diagnosis as an abnormality: *"When you think of mental illness you don't think of it as something good, you know it's a mental illness you won't be able to have a normal child" (Student 6); "They're not okay with it, they think it's a bad thing" (Student 1)*. Mental illness is associated with abnormal behavior (Lauber et al., 2006), and Arabs tend to tolerate mental health difficulties and disorders as long as they do not result in out of control or disgraceful behavior (Al-Krenawi, 2005). However, it appears that shame and disgrace are automatically associated with mental illness even in the absence of abnormal behavior.

2.3 Fearful: dangerous and unpredictable

One of the most common beliefs identified in this analysis and presented in previous research is the idea that individuals with mental disorders are dangerous, violent and unpredictable (Phelan et al., 2000): *"They're viewed as very unstable and you don't want to get in the way of that, you don't want to get attacked" (Student 5); "They think of them as insane people" (Student 2); "They think they're crazy" (Student 3); "There's always the person that talks to you but two steps back making sure they're at arms length so that they can run" (Student 4); "Everyone is scared of people with mental illnesses" (Student 6)*

These beliefs provoke fear in the public and lead to the rejection and the isolation of people with mental illnesses (Martin et al., 2007): *"When they see people who are different...they think 'okay these people are dangerous people, these are the people you don't want to be around' so they start pushing away" (student 2); "They are afraid of their reaction" (Student 3); "They discriminate against them because they're worried that there is a certain trigger that will make them explode" (Student 4); "If they mention they have a mental illness they're going to start being distant...They're going to be scared" (Student 6).*

Participants on the other hand did not believe that mental illness was linked to dangerousness: *"It doesn't really affect someone's sense of right or wrong... They don't do anything to put you in danger" (Student 5); "No, what I think is dangerous is*

putting them with the wrong people...they need the right people to take care of them" (Student 2); "I absolutely don't believe that...It has nothing to do with their mental status" (Student 3).

Nevertheless, participants expected such beliefs from the public and they associated these views with a lack of knowledge around mental illness: *"It's easier to say all mental people are crazy and they're all dangerous instead of trying to understand" (Student 3); "They're not a threat to anyone it's just that no one understands them" (Student 6).* Students believed that their own views shifted once they had contact with a friend or family member with a mental illness or when they gained knowledge around the topic. However, not all adolescents are faced with such experiences, hence, their initial negative views may be maintained.

In relation to crime, mental illness was perceived as *"You know in monopoly you get the 'get out jail' card" (Student 5),* which suggests that people with a mental disorder that commit a crime may be exempt from the usual punishment due to the belief that they have no control over their actions: *"Because they have a mental illness their time and what they do would be much less" (Student 5); "I'm pretty sure there are several court cases where it's like okay he has a mental disorder, don't send him to jail" (Student 1).*

Two students stated that they feared people with mental disorders due to the media's negative portrayal of mental illnesses; however, contact and knowledge

appeared to eliminate such beliefs: *"So yeah if you're going to show that, obviously I'm going to be scared" (Student 1); "I would be really scared of people who had mental illnesses", "But without having a cousin that has autism I would have never actually understood people with mental illnesses... But now since I have someone close to me that has a mental illness I'm more interested about it and I understand it better" (Student 6).*

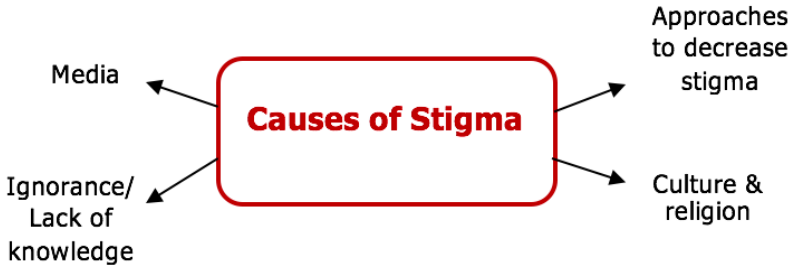
2.4 Burden

Participants stated that the public views people with mental disorders as a burden both on society and on their caregivers: *"They don't want to deal with someone who has a problem" (Student 3); "They don't want that burden on their lives, they're afraid" (Student 5); "They don't want to put the effort and support the person... 'It's too tiring'" (Student 6); "Anything in life that could be a burden or an obstacle, they try to keep out of the way" (Student 2).* It was also predicted that individuals with mental disorders would be viewed as a burden in the workplace and slow down the progress of the company due to their own personal needs: *"No matter how good of an employee I am going to be, employers are going to look away from that because at the end of the day they don't want to go through that extra work" (Student 2).*

While students acknowledged that mental illness may be viewed as a burden by the public, another significant concept emerged: the personal experience of

individuals with mental disorders feeling like a burden on society. This experience may inhibit people from sharing their struggles out of fear of disturbing or troubling those around them: *"If I had a mental disorder I think I wouldn't want to bother anyone, I would definitely try and do things on my own", "I wouldn't want my mom to just drop everything" (Student 1); "Most people do avoid speaking up because as I said they don't want to seem dramatic" (Student 2); "I think people with mental illnesses don't want people around them to feel uncomfortable so they'll hide it" "They don't let them in because they're worried that they'll have to alter their lives to fit their illness" (Student 4).* It is important to point out that students did not report experiencing such situations first hand, yet they were aware of the existing stigma and beliefs. In support, Wahl et al. (2007) found that stigmatizing behaviors and attitudes emerge during middle childhood and intensify with age. Thus, the importance of emphasizing early education around such matters in order to prevent the spreading of discriminatory beliefs and behaviors.

Theme 3: Causes of stigma



Many factors promote stigmatizing attitudes and beliefs (Gerlinger et al., 2013). This theme highlights the main causes of stigma based on the students'

opinions. Three sub-themes will explore stigma in relation to media, lack of knowledge, culture and religion. One sub-theme will display the students' suggestions on how to decrease stigma. This sub-theme is crucial as it provides the researcher with future recommendations to target Arab adolescents and promote change.

3.1 Media

Mass media is recognized as a significant factor that contributes to the stigmatization of mental illness (Stout, Villegas & Jennings, 2004; Wahl, 1992) and is considered the most common source of information regarding mental disorders (DYG, Inc., 1990). Participants in this study highly acknowledged the negative impact of media on mental illness: *"The way they interpret them in movies and TV shows and just the news" (Student 1); "It's in the media, a lot of movies you watch these days people with mental disorders are the ones that are like murders or the ones killing themselves...There's social media too...The news is also a big thing" (Student 2); "From media and movies, that's actually where everyone gets their information from" (Student 3); "I think because its portrayed negatively in the media", "I've never watched a TV show or movie with someone who has a mental illness who isn't crazy or goes crazy at the end" (Student 5); "Because of movies, everyone watches movies, I literally have five movies in mind" (Student 6).*

Students believe that the news tends to connect mental illness and crime as a way of finding a quick and easy explanation around the intentions of crimes being

committed. This may be explained by the need to make news headlines more interesting and perhaps calm the public by blaming it on mental illness which is perceived as a lack of control of one's behavior: *"If they say that person has a mental disorder then they would be like 'oh ok, it makes sense'" (Student 2); "I think media has one of the biggest input because when you find out about mental illness its always in the media", "What makes headlines is the illness that caused that and it just causes more stories to follow up" (Student 4); "As soon as something happens they blame it on mental illnesses. And it gives a bad portrayal of mental illnesses" (Student 5).* In accordance, Stout et al. (2004) found that newspapers frame the topic of mental illness negatively rather than positively.

Ma (2017) reviewed a total of 41 studies published between 2003 and 2013 that investigated media portrayals of mental illness and its negative impacts and found that media played a crucial role in maintaining and promoting mental illness stigma. Similarly, Wahl (1992) reviewed four decades of published studies on the impact of media on the portrayal of mental illness and the results indicated that media influenced the knowledge and attitudes of the public and promoted negative depictions and unfavorable attitudes: *"It's all because of media and what movies represent" (Student 3); "Every time something happens they just tie it to a mental illness, there is so much bad media regarding mental illnesses", "It's always people talking about 'oh yeah this person that had this severe type of mental illness shot up a bank, shot up anything, or they killed themselves'...so there is always this negative outlook" (Student 4); "You see an exaggeration of mental illness in the media, so it*

causes people to think that's how people are" (Student 5); "I've seen it in many movies that they start pulling their hair out they start scratching themselves they start hitting people" (Student 6).

The students strongly acknowledged media as a source of information and believed that most of the public's knowledge on mental illness, as well as their own, was acquired from media outlets such as movies, TV shows, the news and social media. This caused the public to fear individuals with mental illness due to the emphasis on the relationship between mental illness and crime and violence. Participants further recognized the impact of the news, which is considered as a reliable source of information by the public, on mental illness stigma: *"Look at BBC and CNN...regardless of how reliable it is and how much they try to be unbiased, there is a bias to it" (Student 4).*

3.2 Lack of knowledge/ Ignorance

According to participants, the public's main source of information on mental illness is through media. Students believed that media was not a reliable source due to its emphasis on the negative and in some cases inexistent aspects of mental illness such as unpredictability and dangerousness. Hence, they attributed mental illness stigma to lack of knowledge and ignorance: *"I feel like people are not educated enough on mental disorders, they don't understand what a mental disorder is" (Student 3); "People don't even know what it is and when you say it they're just like*

extremely confused", "It's just their ignorance is weighing down their actual insight on this" (Student 4); "They don't get it. They don't understand it and they don't want to understand it" (Student 1); "They've never been in that state of mind, so they don't really understand it" (Student 2); "Even in our time, in my generation, there's a lack of knowledge, no one wants to learn, it doesn't really matter to them" (Student 6).

Moreover, participants believed that the lack of information and knowledge on mental illness hinders the public's ability to help and support those in need: *"People need to be more educated about mental diseases in order to know how to treat mental people and stop the discrimination" (Student 3); "But then again they don't know what its like to deal with someone who has a mental disorder" (Student 1); "A lot of times they're not really helping and they just don't understand what's actually going on" (Student 2); "They don't want to ask, they don't want to research about it...They just want to avoid the topic completely" (Student 6).*

One participant suggested that negative beliefs are passed on from generation to generation. He believed that the older generation impose their old mentalities onto the youth and often attempt to appear more evolved and accepting, however this is not the case: *"People have this old mentality, and this passes from generation to generation...They're changing the way they're speaking to be more open minded and to seem more welcoming, but really the words they're saying are very hurtful for people" (Student 5).*

In the Middle East mental illness is commonly attributed to weak personalities, low self-confidence and unhealthy lifestyles, moreover, individuals are viewed as responsible for their condition (Al-Darmaki et al., 2015). These false beliefs emerge in the absence of knowledge and they are viewed as a barrier for seeking support from mental health professionals.

3.3 Culture and religion

Characteristics of the Arabic culture were viewed as factors that may strengthen stigma towards mental illness. Previous studies have identified negative beliefs towards mental illness within the Arab population (Al-Darmaki, 2003; Al-Krenawi, 2005). Moreover, concepts such as shame, embarrassment and rejection were attributed to mental illness stigma in the Arab world (Hijawi et al., 2013; Angermeyer et al., 2004). The analysis was able to shed light on the specific cultural factors that students acknowledged had an impact on mental illness stigma. These include a major concern of one's public image and the judgmental nature of this society: *"Specifically in this area of the world everyone thinks that they are better than others" (Student 2); "I feel like the Arab society are not open and they don't see so many people with mental illnesses, they are very closed in a society and they have expectations" (Student 3); "Especially in our society you feel very pressured and you feel like you cannot really express yourself", "We live in a toxic society...it's a very judgmental society...it's almost like all eyes are on you", "Parents are too afraid of*

people judging their children to get them help" (Student 5); "In Kuwait we are used to 'oh you can do whatever you want, if you fail that's okay we'll take you to another school'...Everything comes easy for them" (Student 6).

Religion on the other hand was viewed as both a positive and negative influence. A number of participants recognized that Islam teaches one to be kind, loving, accepting and more importantly committed to the support and care of those in need. Nevertheless, it appeared that people were drifting away from the positive teachings of Islam: *"In the Qur'an if you took care of someone with a disorder then you go straight to heaven...All you have to do is be nice" (Student 1); "For example Islam, obviously we learn to take care of the person but obviously now everyone is moving away from religion so no one's really focusing on that part" (Student 2); "All religions are very peaceful...the overall point is peace but you know when people take context from it" (Student 5).*

According to participants, the negative impact of religion came in the form of superstitious beliefs and the tendency to rely on religion as a cure for mental illness. Research suggested that Arab Muslims were more inclined to visit a religious healer to treat mental illness (Al-Darmaki & Sayed, 2009; Hamid & Furnham, 2013), and attribute the causes of mental illness to the possession of evil spirits or the evil eye (Weatherhead & Daiches, 2010; Fadlalla, 2005): *"If you think about it in a religious sense then you would expect them to be more positive about it...And it's like they're not really trying to their part" (Student 1); "I think there are a lot of people that*

believe that religion will cure it...it should be treated like a physical illness" (Student 4); "Lots of people think that mental illness are a punishment from God or the devil talking to you" (Student 5).

3.4 Approaches to decrease stigma

All participants made suggestions around different approaches that may decrease mental illness stigma. While the third theme focused on the causes of stigma it was important to include the potential solutions to tackle this issue from the students' perspectives since they are the target population. The youth have been identified as an important target in several studies (Arboleda et al., 2008; Corrigan et al., 2012; Time to Change, 2012; Wright et al., 2005) due to the onset of a variety of disorders during adolescence (Amminger et al., 2006) as well as the tendency for younger individuals to begin stigmatizing during middle childhood (Wahl et al., 2007).

The suggestions included the need to approach the public through the internet. Moreover, an emphasis was placed on encouraging more positive portrayals of mental illness in the media: *"Best thing I think would be movies. If they actually made a movie about someone who has a mental illness and explain what he is going through and would make him look better, they show he is living a normal life, how he is going through everyday" (Student 2)*; *"Maybe the media, maybe presidents or something...there are lots of different parades and different posters and hashtags on social media" (Student 4); "In the media giving examples of stable mental people" (Student 5); "There's the internet...if you want to get to everyone that's your way to*

go" (Student 1), this student suggested online surveys that the public would fill out in order to gain insight on how they can personally help those in need.

Participants also emphasized the importance of educating the public: *"More people need to learn about it" (Student 2); "People need to be more educated about mental illness...because if someone doesn't want to be educated about a topic nothing is going to change that" (Student 3); "You should start telling people in my generation and younger generations and spreading awareness...I feel like they don't understand, zero knowledge on the topic" (Student 6).* Furthermore, students stated that normalizing mental illnesses and publically speaking about personal experiences in dealing with mental health difficulties would promote more accepting behaviors: *"I think just normalizing the amount of people that have it, you have to recognize that they are a part of this society...normalize it and say 'look this person has it, it's okay if you do too', to make the person feel comfortable" (Student 4); "I think normalizing it...Having people speak up about it" (Student 5).*

One student suggested implementing laws that would protect the rights of those suffering from mental disorders: *"Laws, laws are the only way people are going to follow something" (Student 3).* This is an important point because Kuwait lacks mental health legislations (Al-Krenawi et al., 2004). Another student suggested public events: *"They're usually for schools, like why can't we make an expo for mental illnesses or a marathon...A movie night, I would go to be honest I really love movie nights" (Student 6).*

CHAPTER 4:

OVERALL DISCUSSION

OVERALL DISCUSSION

Summary and Integration of Findings

Firstly, the choice of language around mental health within the thesis was briefly discussed in Chapter 1. It is important to clarify the researcher's rationale for using the chosen language and conceptualization of mental health. Throughout the research process and the write up phase the researcher alternated between statements related to the medical model of mental health such as 'mental illness' and 'mental disorder' and the humanistic approach to mental health and counselling psychology such as 'mental health difficulties' and 'mental health issues/problems'. The majority of the literature around mental health stigma refer to mental health issues through the medical model and focus on the effects of stigma on people with a diagnosis of a mental disorder. Moreover, the public's lack of knowledge around mental health may impact their ability to comprehend the spectrum of mental health difficulties as they may be more familiar with the concepts of mental illness and mental disorder. Thus, the researcher aimed to place all the concepts under a single umbrella in order to normalize mental disorders by alternating between the different languages.

Nevertheless, counselling psychology is influenced by the humanistic approach rather than the medical model of mental health. Therefore, the usage of a medical language when referring to mental health may have certain implications. While some

researchers believe that the medical model may reduce stigma (Corrigan et al., 2008), controversial evidence from a meta-analysis (Kvaale et al., 2013) demonstrated that the medicalization of mental disorders may increase stigma and discrimination. Biological explanations for mental health issues lead the public to attribute more blame and increased the public's desire to maintain a distance between themselves and people suffering from mental health problems. This study focuses on the overall spectrum of mental health which include minor mental health difficulties as well as more complex issues which may lead individuals to receive a diagnosis from a mental health professional. Hence, the researcher aimed to include all levels of mental health problems within the study by referring to mental health difficulties and mental health illnesses in order to normalize the phenomenon and promote a more inclusive and accepting approach.

The attempt to include the full spectrum of mental health issues allowed the researcher to highlight relevant information that would benefit the field of counselling psychology. Counselling psychologists provide support to clients that present a wide range of mental health difficulties, thus the importance of including all types of issues ranging from minor difficulties to more complex diagnoses. The aim of the study is to provide counselling psychologists with relevant information and strategies on how to tackle stigma both within therapeutic sessions as well as public settings. For instance, the results of the study may shed some light on the importance of exploring the effects of public stigma and self-stigma on the client's well-being within the therapeutic setting. The consideration of cultural variations is also an important factor

to consider when supporting clients and collaboratively developing coping mechanisms that may aid them to overcome such issues.

The study also highlights the crucial need for counselling psychologists to engage with the public in order to enhance their knowledge around mental health and mental health services. Counselling psychologists may consider attending schools and professional settings to provide the public with knowledge on how to seek help, how to recognize mental health difficulties and how to provide support to loved ones. Moreover, counselling psychologists may consider the utilization of social media as a platform to promote mental health awareness and appear more accessible to the general public. This study highlights the benefits of an educational intervention and the importance of educating the youth. In addition, it provides information on the ways in which stigma is displayed within this population. Thus, counselling psychologists may utilize this information to inform future strategies to decrease stigma and increase knowledge on how to address the issue within therapeutic and public settings.

Using a mixed methods design, the researcher investigated attitudes towards mental illness using a thematic analysis to gain an understanding of Arab adolescents' views towards mental health and people suffering from mental disorders and difficulties. The quantitative study set out to explore the impact of an educational intervention on students' initial beliefs with the aim to promote more accepting views. The literature search showed that previous studies focused on mental illness stigma

and interventions primarily in Western cultures, however, there was an apparent lack of research on mental illness stigma in the Middle East. While some researchers had explored public views towards mental illness in the Arab region, no research investigated the impact of interventions that aimed to reduce public stigma.

According to the World Health Organization (2017) 1 out of 4 people suffer from mental disorders worldwide with approximately 322 million people suffering from depressive disorder. Of the 322 million cases, 16% represent Eastern Mediterranean regions (WHO, 2017). Despite the high prevalence of mental illness worldwide, individuals suffering from mental health difficulties are reluctant to seek support (Slade, Johnston, Oakley Browne, Andrews & Whiteford, 2009). That being said, stigma has been identified as one of the main barriers to help seeking behaviors (Bowers et al., 2013). Accumulating evidence has shown that early treatment of mental disorders contributes to improved outcomes and overall functioning of individuals suffering from mental health difficulties (Marshall, Lewis, Lockwood, Drake, Jones & Croudace, 2005; Perkins, Gu, Boteva & Lieberman, 2005). Therefore, efforts to decrease stigma may encourage individuals to gain easier access to mental health services and improve mental health amongst the youth (Yamaguchi, Mino & Uddin, 2011).

The mixed methods approach used in this study allowed the researcher to combine both quantitative and qualitative approaches with the aim to widen the scope of research and counterbalance weaknesses of either approach on its' own

(Driscoll, Appiah-Yeboah, Salib & Rupert, 2007). Findings from the quantitative study showed that a brief educational intervention has the capacity to alter initial beliefs towards mental illness in adolescents. Similarly, Mino, Yasuda, Tsuda and Shimodera (2001) found that short lectures around mental health can change young people's stigmatizing attitudes. Nevertheless, according to Rao et al. (2007), mental illness and mental illness stigma are concepts that are deeply tied to culture. Due to the complexity of mental illness stigma and its variation across diverse cultures, the qualitative study enabled the researcher to gain a deeper understanding of the phenomenon within the targeted population. Thus, the mixed methods approach provided the researcher with the opportunity to investigate the matter and assess an intervention to tackle the issue.

Abdullah and Brown (2011) highlight the importance of considering culture, social norms and psychological processes when conducting research around stigma. Several studies that investigated mental illness stigma found that culture plays a crucial role in the variation in stigma experience (Angermeyer, Buyantuga, Kenzine & Matschinger, 2004; Littlewood, Jadhave & Ryder, 2007; Weiss, Jadhav, Raguram, Vounatsou & Littlewood, 2001). Hence, the qualitative study aimed to eliminate the assumption that stigma operates similarly across cultures by investigating the ways in which social norms and values impact the presentation of stigma within a specific population. In accordance with previous research which explored Arab's attitudes towards mental illness (Al-Krenawi, 2005), findings from the qualitative study found that such beliefs were negative and deeply tied to culture and religion.

The impact of culture and religion on negative attitudes towards mental health could be understood in relation to attribution theory. The theory allows researchers to understand the public's reactions towards people suffering from mental health difficulties by exploring causal attributions made by the public around certain behaviors (Corrigan et al., 2003; Martin et al., 2000). The two main constructs that explain human motivation to make such attributions are stability of causes and controllability of causes. Findings from this study and previous studies investigating Arab's views revealed that mental illness is a result of weak personalities and that the individual is responsible for their condition (Al-Darmaki et al., 2015). Such beliefs generate negative emotions and behaviors such as fear, anger and a desire to maintain distance between themselves and individuals with mental health issues. Moreover, religious attributions such as the belief that mental health problems are a result of one's weak faith or a punishment for one's sins or the result of the evil eye significantly increase stigmatizing attitudes. In addition, such attributions suggest that the individual is not in control of their condition which in turn leads to emotions of pity towards people suffering from mental health issues (Dooley, 1995; Schmidt & Weiner, 1988), and the fear that they may exhibit unpredictable behaviors (Lauber et al., 2006; Phelan et al., 2000).

The thematic analysis revealed that participants acknowledged the Arab society's tendency to attribute mental illness with dangerousness, incompetence and fear. These beliefs are the most common stereotypes held by the public towards people suffering from mental disorders (Atilola & Olayiwola, 2011). More specifically,

students believed that shame was highly associated with mental illness stigma within their society. A diagnosis of a mental illness is considered to be a shameful label to the individual and the family due to the importance given to one's public image. Arab adolescents are reluctant to seek help due to the fear of bringing shame to one's family and being perceived as weak (Al-Darmaki, 2003; Hijawi et al., 2013). Moreover, family members conceal, delay and deny treatment in response to the shameful experience of a family member's diagnosis (Saxena et al., 2011; Shibre et al., 2001). Similarly, several students in the study expressed a reluctance to expose their own mental health difficulties out of fear of being judged by the public. Because public image is highly valued within the community, individuals are expected to act accordingly and display positive behaviors when representing one's self and one's family.

The latter highlights the importance of considering the detrimental effects of self-stigma alongside public stigma. Self-stigma, as previously mentioned, occurs when individuals with mental health problems internalize negative stereotypes which result in diminished self-esteem and a decrease in self-efficacy (Corrigan et al., 2006). This phenomenon could be observed in the participants' reluctance to share their distress with their families and the public out of fear of being judged negatively. Students stated that their mental health difficulties would be considered a burden on their families. Such expectations highlight the possibility for participants to view themselves as a negative burden or a shameful member of the family if they were to experience mental health issues. Major and O'brien's (2005) 'identity threat model of

stigma' suggests that stigmatized individuals experience 'expectancy confirmation' which refers to the anticipation and expectation that the public will engage in discriminatory behaviors towards them. This leads to 'automatic stereotype activation' which refers to the stigmatized individual's automatic reaction of reinforcing such cultural stereotypes. The latter impacts student's perceptions of certain situations even in the absence of discriminatory behavior (Crocker, 1999). For instance, one participant in particular decided to conceal his diagnosis at school out of fear and an expectancy of being treated differently by school staff. Nevertheless, it is important to mention that knowledge on the public's views towards mental illness does not always lead to self-stigma (Crocker & Major, 1989). Some individuals may be aware of the shared negative stereotypes without necessarily applying it to themselves.

A study conducted by Al-Krenawi (2005) found that mental health difficulties are tolerated within the Arab community as long as they do not result in out of control or shameful behavior. Therefore, cultural norms enable the public to determine whether behaviors are considered normal or abnormal. For instance, according to Al-Issa (1995), hearing imaginary voices and having visions may be perceived as normal in certain Middle Eastern cultures, whereas in the Western cultures such occurrences are categorized as hallucinations associated with mental disorders. Hence, the importance of considering a culture's social norms and values when conducting research and designing interventions.

Participants also identified religion as a factor that highly contributed to the stigma of mental illness. While Islam highly values the care of those suffering from physical and mental illnesses, students believed that the public did not implement such values in regards to mental illness. Findings from the qualitative study confirmed findings from previous research which suggested that Arab Muslims believed that mental illness is a result of a possession by evil spirits (Aloud & Rathur, 2009; Watherhead & Daiches, 2010), or is a result of the evil eye which is considered a form of jealousy which impacts the good fortune of others (Fadlalla, 2005). Mental illness is also perceived as a test from God or a form of punishment in response to one's sins (Weatherhead & Daiches, 2010). Furthermore, Al-Krenawi et al. (2008) suggested that the rejection of mental health services in the Middle East may be due to the perception that mental health systems represent Western cultures and ignore Arab Islamic values.

Participants believed that lack of knowledge around mental illness and mental health in general was one of the main causes of stigma. Mental health literacy is the knowledge one has around mental illness and its risks, the ability to recognize mental health problems and the knowledge on how to seek support and access mental health services (Jorm, Korten & Jacomb, 1997). Studies have shown that young people and adults have similar mental health literacy deficits (Jorm et al., 1997; Kelly, Jorm & Rodgers, 2006; Wright, McGorry & Harris, 2006; Burns & Rapee, 2005). However, young adults (18-25 years) were better able to identify depression compared to adolescents (Wright et al., 2006). Thus, the importance of increasing

mental health literacy in younger generations with the aim to decrease stigma. The inability to recognize mental health problems among the youth (Barker, Olukoya & Aggleton, 2005) and their parents (Logan & King, 2001) hinders help seeking behaviors. Students from both studies expressed a lack of knowledge around mental health and psychology in general. Following the educational interventions participants expressed a strong desire to acquire further knowledge around mental health services in the country as well as educational opportunities within the field of psychology. These reactions suggest that students had no previous knowledge around such matters.

Movies and social media were recognized by students as main sources of information in regards to mental disorders. They believed that false opinions around mental illness were due to negative portrayals of mental disorders in the media. Stout et al. (2004) also recognized media as a significant contributor to the stigmatization of mental illness. Media is considered one of the main sources of information regarding mental disorders (DYG, 1990). Several students stated that headlines in the news appeared more interesting when crimes were associated with mental illness. In accordance, Stout et al. (2004) found that mental illness is portrayed negatively rather than positively in newspapers. The consequences of such beliefs lead to discriminatory behaviors where the public is less likely to lease apartments to individuals with a mental disorder (Page, 1995) and less likely to hire someone with a mental illness (Bordieri & Drehmer, 1986).

While the quantitative study demonstrated the benefits of a brief educational intervention and its impact on negative attitudes, findings from the qualitative study complemented these results by providing information around how social norms and culture influence the ways in which stigma is displayed within a specific population. Corrigan and Watson's (2002) theoretical model 'social psychological perspective on public stigma' suggests that stigma consists of three elements: stereotypes, prejudice and discrimination. This study was able to explore the shared stereotypes and prejudice towards individuals with mental illnesses, however, discrimination which is the behavioral outcome of stigma was not assessed in the study. While participants in the qualitative phase predicted negative attitudes from the public, their own personal opinions towards people with mental illnesses appeared to be positive and accepting. All students expressed a willingness to marry, hire and support someone with mental health difficulties. Nevertheless, their positive attitudes were accompanied with conditions such as the willingness to marry someone with a disorder as long as it did not impact their own well-being and as long as they were able to clearly communicate with their partner. Willingness to hire someone with an illness also came with conditions such as the need to conduct regular check-ups with the individual and ensure that they are stable on medications.

The latter may suggest that although students may express positive attitudes, these may not be reflected in their behaviors. The theory of planned behavior (Ajzen, 1991) suggests that individuals are more likely to engage in a behavior depending on three factors. The first is the extent to which the individual views the planned

behavior as favorable or unfavorable. Participants in the study reported having positive views towards mental health after they gained further knowledge on the topic. Thus, highlighting the importance of directly altering the public's views through education in order to encourage more positive behaviors. The second factor refers to the perceived social pressure to either preform or not preform the behavior. Students in the study stated that they expected negative reactions from the public towards people suffering from mental health difficulties. This suggests that there is a lack of perceived social encouragement to engage in positive behaviors towards people in distress. Therefore, if attitudes are altered at a wider scale within a population individuals are more likely to engage in positive behaviors that are expected and encouraged by the public. Lastly, the final factor refers to the perceived ease or difficulty in conducting the behavior. Students reported having minimal information around available mental health services and previous studies suggested that Arabs were more inclined to visit a religious healer rather than a mental health professional (Al-Darmaki & Sayed, 2009; Al-Krenawi, 2005). Hence it is crucial that counselling psychologists facilitate access to services and engage directly with the public in order to enable help-seeking behaviors.

Moreover, the theory of planned behavior (Ajzen, 1991) proposes that behavior is predicted by behavioral intentions and the motivation to engage in such behaviors. However, research assessing educational interventions which aim to promote more accepting attitudes suggest that changes in knowledge and attitudes do not reliably predict behavior (Chung & Chan, 2004; Tolomiczenko et al., 2000).

Therefore, changes in attitudes may not be sufficient enough to decrease discriminatory actions. Thus, future interventions should aim to be multi-faceted and target behavioral changes alongside attitude alterations. Schachter et al. (2008) argue that an increase in empathy and contact with people suffering from mental disorders may produce substantive behavioral change (Crisp, Gelder, Rix, Meltzer & Rowlands, 2000; Gordon, 2005; Rickwood, Cavanagh, Curtis & Sakrouge, 2004). Many sources have highlighted the benefits of using contact interventions (Battaglia, Coverdale & Bushong, 1990; Couture & Penn, 2006; Herbert, Voyer & Valois, 2000; Meise et al., 2000).

A meta-analysis conducted by Corrigan et al. (2012) which included 79 intervention studies highlighted the benefits of educational and contact based interventions in reducing stigma. Nevertheless, the results showed that contact was more effective when targeting adults and education was more beneficial when targeting the youth. In the current study students were asked to complete a background information sheet prior to the talks. Participants were asked to report whether they knew someone with a mental disorder and 76 students (74.3%) in the quantitative study reported that they did. Nevertheless, results from this study indicated that although many of the students had previous contact with an individual with a mental illness, their attitudes were only altered in the presence of knowledge. Moreover, only 6 students (5.7%) chose to take a psychology class as an elective in school. It is possible to suggest that this study's findings around student's higher levels of social restrictiveness and lower levels of benevolence prior to the talks may

be due to the lack of knowledge around mental illness. Thus, once again demonstrating the relevance of using educational approaches when targeting the youth.

The literature search has highlighted three different approaches that aim to decrease stigma: education, contact and protests (Corrigan & Watson, 2004; Schachter et al., 2008; Wei et al., 2013). When choosing an approach, it is important to take several factors into consideration such as the age and maturity of the targeted population, their culture, and their initial beliefs towards mental illness. This study was educational in nature, however, the interaction between the students and a mental health professional in both studies may also be viewed as a form of contact that further impacts the outcomes of the interventions. This interaction may potentially discard the belief that mental health services are inaccessible and provide more clarification around the role of mental health professionals. This is especially important due to Arabs lack of knowledge around the role of mental health professionals which is believed to encourage negative perceptions towards mental health in general (Al-Qutob, 2005).

Due to the overall exploratory nature of the study, the researcher aimed to gain further insight from participants around their opinions on potential interventions that the youth may respond to. Since adolescents are the targeted population, their input and feedback on possible future approaches to decrease stigma was highly valued. Chen, Koller, Krupa and Stuart (2016) highlight the importance of using youth

culture as a strategy to engage and connect with adolescents. The youth are an important target due to the onset of mental health difficulties during adolescence (Corrigan et al., 2012; Amminger et al., 2006) and the tendency to begin stigmatizing during middle childhood (Wahl et al., 2007). Students suggested several strategies that they believed adolescents would respond to. They recognized a need to increase knowledge and awareness around mental health problems through social media outlets, movies and public events. Studies have shown that media has played a crucial role in maintaining and promoting mental illness stigma (Ma, 2017). Media is also a channel that would enable access to all age groups and promote change on a wider scale. This is particularly important because adolescents are still reliant on their parents, therefore, educating the parents on how to recognize mental health problems and access appropriate support is as essential as educating the youth (Logan & King, 2001).

Limitations of the study

Data was collected from a group of students that attended the same private high school, therefore, the generalization of data may be impeded. Most of the students shared similar backgrounds which suggests that findings may only apply to this specific group. Students attending the private American International School of Kuwait come from upper middle-class families and their experiences may not reflect those of students that attend Kuwait's public schools. Moreover, the school's curriculum is highly challenging since the majority of students are enrolled in

International Baccalaureate (IB) classes which reflects their advanced level of education compared to other private schools. Previous studies have been criticized for representing specific types of school since they do not represent the diversity of the population (public, private, single-gender schools) (Spence & Shortt, 2007). Hence, it is important to target a variety of school types in order to compare results and highlight apparent gaps.

Although the results of the quantitative study were highly significant in terms of changes in attitudes post-intervention, a follow up study was not conducted in order to assess the longitudinal effects of the talks. While educational interventions may yield short-term positive effects, the maintenance of such changes are not guaranteed (Chan, Mak & Law, 2009; Finkelstein, Lapshin & Wsserman, 2007; Schulze, Richter-Werling, Matschinger & Angermeyer, 2003). Results reflect the immediate reaction of students in response to the talks. Moreover, students that took part in the interviews of the qualitative research were asked whether they were aware of the study that was taking place in their school and their responses suggested that they were not. Nevertheless, they may have been conscious of the expectations since interviews were conducted following the quantitative phase of the research. Participants in the quantitative study may have discussed their experiences with students from the qualitative study.

It is possible that students' responses did not truly reflect their actual attitudes for several reasons. Firstly, social desirability bias may have impacted their responses

as they attempt to answer based on public expectations (Grimm, 2010). Additionally, they may have wanted to please the researcher by providing answers that would promote desired outcomes although the aims of the research were not directly made clear to the students. Nonetheless, in light of the limitations this study faced, the findings provided valuable insight considering that this research was the first of its kind in this region of the world. As previously mentioned, the study was an initial investigation of the phenomenon and aims to inform future strategies and approaches that may be applied in upcoming research.

Suggestions for future studies

According to Schachter et al. (2008) previous studies that examined the effects of education and contact, assessed attitudes towards mental illness, attitudes towards mental health professionals (Battaglia, Coverdale & Bushong, 1990) and help seeking attitudes and intentions (Battaglia et al., 1990; Esters, Cooker & Ittenbach, 1998; Rickwood, Cavanagh, Curtis & Sakrouge, 2004). However, no study explicitly aimed to assess stigma arising from an interaction with mental health professionals. It may be helpful to explore this area in order to gain a deeper understanding of causes that influence the increase of stigma. This is especially important in Kuwait due to the lack of mental health legislations which may impact the quality of services.

This research may be considered as a gateway into understanding mental illness stigma and interventions to decrease discrimination within the youth in the

Arab world. Future research may focus on investigating the presence of stigma within adolescence attending public schools in order to compare findings and gain insight on differences and similarities between each population sample. Moreover, future investigations may focus on adult's views towards mental illness in Kuwait since attitudes and beliefs are transferred from one generation to the other. Future strategies should focus on educating the general public and aim to promote overall changes across all age groups within this population.

The present study examined the impact of educational approaches on adolescent's views. In order to encourage changes in attitudes and promote more accepting behaviors, future studies may focus on testing other interventions and gain further knowledge on which approaches yield the best outcomes when targeting Arab students. For instance, studies may assess the effects of educational interventions accompanied with contact interventions. Additional evidence on the impact of culture and religion on mental illness stigma may also inform future strategies when targeting a specific group. A study conducted by Anglin, Link and Phelan (2006) found that cultural variations exist not only in stigmatizing attitudes but also in discriminatory behaviors related to stigmatizing attitudes.

While this study aimed to gain insight on shared beliefs towards mental illness, it may be helpful to target adults and students with a diagnosis of mental illness in order to gain a deeper understanding of first-hand experiences in dealing with stigma. This may provide researchers with valuable information on the ways in which

stigma is expressed by the public and experienced by the victims. While public stigma was the central focus of this research, self-stigma has been identified as a harmful outcome of public stigma (Yanos et al., 2015). Hence, the importance of investigating the presence and effects of self-stigma on individuals suffering from mental health difficulties. Self-stigma considerably impacts people's self-esteem and influences their overall health and levels of recovery (Assefa et al., 2012). Thus, it is crucial to focus on approaches that support individuals suffering from mental disorders and encourage help-seeking behaviors.

Lastly, while attitudes and beliefs towards people with mental illnesses were assessed, behaviors were not evaluated. Thus, in order to ensure progress in the arena of mental illness stigma, behaviors in relation to attitudes and behavioral intentions must be assessed in future studies. While changes in behavior may be challenging to measure, it is essential that future research focus on interventions and approaches that enable the assessment of behavioral changes.

Recommendations for counselling psychology

Arab adolescents from this study did not appear to be aware of mental health services in the country and their ability to easily access them when faced with emotional difficulties. Moreover, students in the Education and Careers talk were highly intrigued by the many career options available within the field of psychology since they were initially unaware of the various opportunities. Female students

seemed to respond better towards a career in psychology, nevertheless, male students' interest increased when they found out about sports psychology and forensic psychology. The lack of knowledge around mental health services may be due to the fact that such services are highly neglected, inadequate and stigmatized in the Middle East (Mental Health Atlas, 2011). It is possible to suggest that interactions between counselling psychologists and the youth would encourage the normalization of utilizing mental health services. Leshner (2003) states that 'the centrality of science to modern life bestows an obligation on the scientific community to develop different and closer links with the general population' (p.977). Therefore, it is our duty to engage with the public, share knowledge and promote the development of the field of psychology.

The inadequacy and neglect of mental health services in the Middle East may be tied to the lack of mental health legislations in several countries in the Arab world, including Kuwait (Al-Krenawi et al., 2004). In addition, Arabs hold negative views towards psychiatric and psychological services and find it challenging to trust mental health professionals due to the belief that they lack empathy and genuineness (Al-Krenawi & Graham, 2000; Al-Qutob, 2005). These beliefs emerge in the absence of knowledge around the roles of mental health professionals (Al-Qutob, 2005). These findings suggest that schools may play an important role in promoting mental health and encouraging students to seek support when needed. It also became apparent that students were reluctant to visit the high school counselor out of fear of being judged by their peers. Students that did visit the high school counselor in order to

manage stress and other difficulties requested to have the curtains of the room drawn so other students would not see them. This is worrying particularly for this group of students given that they are receiving an education of very high standards yet they still lack basic knowledge on mental health and mental health services.

Counselling psychologist may organize regular visits to schools and provide students with further information on how to recognize mental health problems, how to seek support and how to provide peers with support. The role of friends during adolescence is highly prominent, thus, peers play a crucial role in the help-seeking process (Rickwood, Deane, Wilson & Ciarrochi, 2005). For instance, students tend to visit school counsellors in order to seek help for one of their peers (Rickwood, 2006). Such intimate relationships are considered to be an important source of support. Chen, Koller, Krupa and Stuart (2016) encourage school-based anti-stigma programs that support students to come up with activities to reduce stigma. Such approaches allow students to take on a leadership role and empowers them to actively promote change. These programs could be held by school counselors or visiting counselling psychologists.

Several studies suggest that Arabs are more inclined to visit religious healers when faced with mental health difficulties in order to avoid public stigma (Al-Darmaki & Sayed, 2009; Hamid & Furnham, 2013), and they turn to mental health professionals as the last option (Gilat et al., 2010). Mental health services are offered in the private sector with only a handful of reputable facilities, otherwise they are offered in Kuwait's public psychiatric hospital. The need to incorporate mental health

services in primary health care in Kuwait has been suggested in order to normalize mental illness and promote the accessibility of services (Alkhadhari, Alsabbrri, Mohammad, Atwan, Alqudaihi, Zahid, 2016; Almazeedi & Alsuwaidan, 2014; AlOkaha et al., 2012). Moreover, counselling psychologists should seek to influence government policies due to the lack of mental health legislations and mental health policies in most Arab countries (Al-Krenawi et al., 2004).

The importance of educating the youth around caring about one's mental health and well-being and accessing services when needed must be emphasized. Three quarters of individuals suffering from mental illness experience the onset of their difficulties between the ages of 16 and 25, a period when young individuals are likely to begin post-secondary education (Mcgivern, Pellerita & Mowbray, 2003). Students that do not seek professional help have lower rates of program completion compared to all other disability groups (Cavallaro, Foley, Saunders & Bowman, 2005; Moisey, 2004). Stigma is considered a powerful barrier in help-seeking behaviors amongst these students (Martin & Owsin, 2008). However, studies have shown that students with mental illnesses who seek and receive the appropriate support are more likely to succeed in post-secondary education (Mcgivern et al., 2003), they are more likely to experience increased levels of self-confidence and self-efficiency (Collins, Bybee & Mowbray, 1998) and are less likely to be hospitalized (Isenwater, Lanham & Thornhill, 2002). A study conducted by McLean and Andrews (1999) found that 65% of 256 participants would not advise their peers to disclose their illness and indicated a regret in doing so themselves. This may lead to a limitation of

opportunities as students attempt to avoid discrimination by concealing their mental health difficulties.

Pilgrim (2009) describes the negative outcomes of mental illness stigma as an experience of depersonalization, rejection and disempowerment. Individuals suffering from mental disorders may internalize negative beliefs and responses and experience low self confidence. Hence, it is crucial that counselling psychologists explore the impact of stigma on their clients' well-being and work collaboratively with them to externalize the negative outcomes of stigma and generate strategies to cope with such experiences. The therapist works on empowering the client during therapy. In the presence of such support, individuals are able to regain and maintain their self confidence and feel empowered and encouraged to achieve their goals. The 'empowerment' pathway presented in figure 1 highlights the effects of either internalizing or externalizing stigma (Martin, 2010):

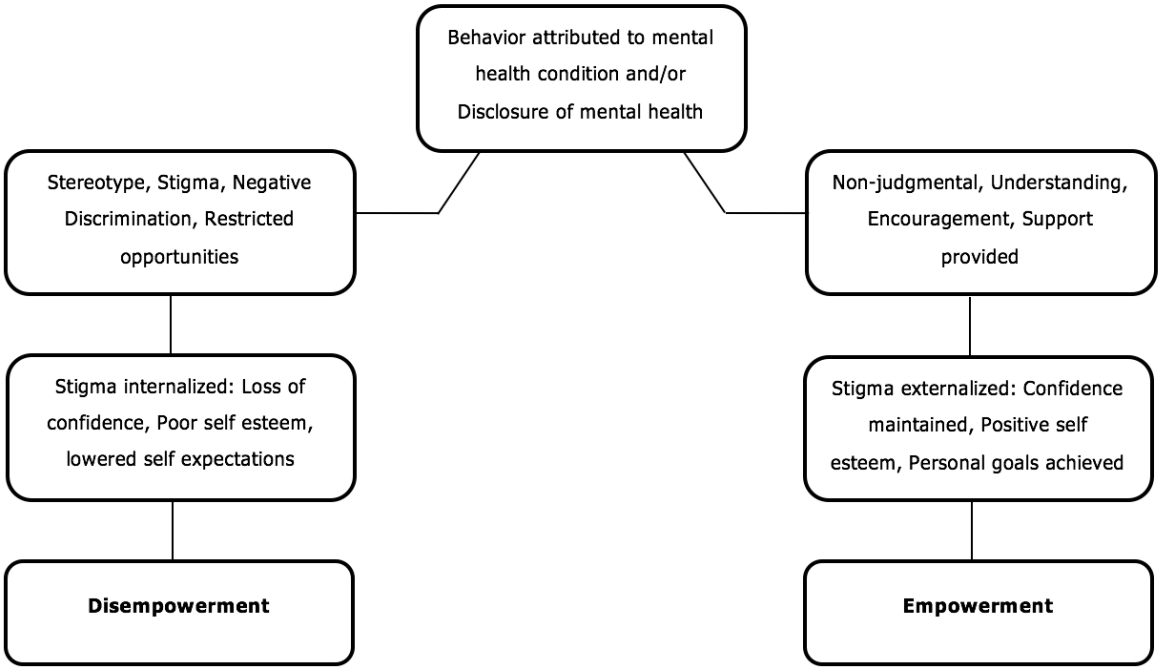


Figure 3. Mental Health Pathways

Lastly, the Gulf War which occurred in Kuwait in 1990 had a significant impact on the well-being of Kuwaiti nationals (Al-Krenawi et al., 2008). Since the conflict between Kuwait and Iraq did not occur long ago, Kuwaitis are still recovering from the trauma caused by the war. Therefore, psychological support is necessary when dealing with the aftermath of conflict. Moreover, the Arab spring, which began in 2010 and is still ongoing, is believed to substantially impact Arab's mental health and well-being (Amawi et al., 2014). The commonality of such revolutions within the region reveals the importance of educating the population around mental health, mental health services and promoting more accepting attitudes towards mental health difficulties. Direct contact with mental health professionals through public events may promote a change in the public's attitudes towards mental health professionals. For instance, psychologists could be encouraged to conduct informative

talks in professional institutions and target adults in order to normalize the usage of services and gain the public's trust through personal contact. Mental health professionals may also use social media as a platform to share knowledge. This strategy would also allow the public to view mental health services and psychologists as more accessible.

Conclusion

This mixed methods research set out to explore Arab adolescent's views towards mental illness and the effects of an educational intervention in promoting more accepting attitudes. Stigma has been identified as a worldwide issue that impedes the well-being of individuals suffering from mental health difficulties across various areas of their lives. Mental health professionals all over the world are responsible of providing their clients with the best care possible. This includes efforts to decrease stigma and discrimination in order to encourage individuals to recognize mental health difficulties and seek support when needed. Researchers have been actively trying to reduce stigma and challenge negative stereotypes around mental illness through various approaches in the Western world. Nevertheless, the Arab region lacks research in this area which in turn inhibits efforts to design strategies to tackle the issue.

The findings of this study provide an understanding of the underlying assumptions and beliefs around mental illness which have never been investigated in

Kuwait. Moreover, it endorsed the benefits of educating the youth with the intention to increase their knowledge and levels of benevolence and decrease their social restrictiveness towards individuals with mental disorders. These outcomes contribute to the initiation of such research in the Arab region. Furthermore, they contribute to a knowledge base for counselling psychologists to develop services, approaches and research that are appropriate for similar populations.

The mixed methods approach fit best with the exploratory nature of the study. Students appeared to significantly lack knowledge around mental illness and mental health services. Their views towards mental illness confirmed findings from previous research conducted in the Western society which indicate that stigmatizing attitudes are present in adolescence. Stigmatizing attitudes stem from the lack of awareness and knowledge on mental illness and psychology in general. Many students were unaware of basic information around qualifications and work opportunities within the field of psychology. This may suggest that psychology is a field that is highly underrated and unrecognized within the region. Nevertheless, a brief educational talk significantly impacted their initial views which indicates that there is hope to promote change in Arab adolescent's views through education.

CHAPTER 5:

CRITICAL APPRAISAL

CRITICAL APPRAISAL

This chapter will allow me to critically appraise the research process starting from the moment I decided to base my research on stigma up until the completion of the project. I will aim to critically evaluate and reflect on the process that has shaped me into an independent researcher-practitioner.

Throughout the process I was faced with obstacles, self-doubt and discouragement. Despite these challenges, the most effortless and incontestable phase of the process was the decision to base my project on mental illness stigma. More specifically, I had a strong desire to explore the presence of stigma in Kuwait, the country I was born and raised in. My wish to investigate the concept was accompanied with a profound urge to explore strategies that would eliminate stigma.

This strong inclination was formed by a personal interest in the topic and a sense of responsibility as a counselling psychologist to confront the issue of stigma and its detrimental effects. During my time working as an assistant psychologist at the public psychiatric hospital of Kuwait, I was confronted with countless situations where I observed the consequences of stigmatizing attitudes and beliefs. Nevertheless, one specific encounter truly saddened me and ever since I felt responsible to tackle the issue in Kuwait, my home. A man had denied his wife the opportunity to be treated at the hospital by mental health professionals out of fear of hindering his daughter's marriage prospects. The man prioritized the public's views over his wife's mental health. As I sat in the session with the head psychiatrist, the

man and his wife, my gaze remained fixated on the woman that was so deeply depressed she was unable to speak or lift her head. Ever since, it became my mission to eradicate the issue step by step.

The first step of my journey began when I decided to become an active member of Kuwait's Mental Health Awareness Association "Taqabal", which translates into "Acceptance". We organized marathons, movie nights and art exhibitions all with the intention to educate the public on mental health. That is when I experienced the benefits of tackling the issue through education. I then decided to apply to the doctorate program and study abroad, nevertheless, I always knew I would return to Kuwait and share the gains of my education in the United Kingdom to fill the gaps back home.

As a child, my curiosity was an evident characteristic of my personality. This curiosity was also considered a defect in a society where secrecy and privacy were highly valued. My extreme desire to enquire about the various human interactions that occurred around me was quickly shut down by the adults. Apparently I was being disrespectful. Nonetheless, this 'rebellious' aspect of my identity has become one of my biggest assets, and for that I am truly grateful. Today not only am I able to embrace it, but I am able to put it into good use; and thus began my research journey.

Firstly, my supervisor's expertise in the topic of mental health stigma was very valuable in promoting a collaborative interest and commitment to the research project. During the initial phase it was decided that a quantitative approach would be employed in order to study the effects of a brief educational intervention in changing adolescents' attitudes towards people suffering from mental illness. I acknowledged my concerns around using statistics since numbers were always a challenging aspect of my education. Throughout high school I avoided math by taking the literature path of the baccalaureate. Nevertheless, I recognized the significance of incorporating a quantitative study in order to explore the phenomenon and thus, decided to face my fears. I struggled with familiarizing myself with the different approaches, terminologies and data analysis on SPSS. Therefore, completing the quantitative section was highly energy and time consuming as I dedicated a significant amount of time to grasp the required knowledge to conduct the study.

While the study was the first of its kind in the Gulf region, previous studies have investigated the impacts of educational interventions. Therefore, I reflected on how to incorporate a novel approach that may be implemented in any country. Due to high school students being the target of the study it was important to recognize the demanding curricula and find a balance between educating them on mental illness without interrupting their school work and schedule. Hence, two crucial factors emerged: 1) Keep the intervention as brief as possible; 2) Tackle the issue directly by focusing the content on false beliefs towards mental illness and the ability to live a stable life despite a diagnosis. Due to the decision to tackle the issue of stigma

directly, a control group which received a talk on educational and career paths in psychology was necessary in order to investigate the impact of actively tackling stigmatizing beliefs. Fortunately, the results showed a significant difference between the intervention group and the control group.

During the process of putting together the study, it was suggested that I incorporate a qualitative phase. The advice was highly appealing as I recognized the need to gain a deeper understanding of students' personal experiences, beliefs and their expectations towards the public's views. Nevertheless, my struggles with the quantitative phase were amplified following the decision to use a mixed methodology. I was overwhelmed with the idea that I would have to significantly familiarize myself with not only one new approach, but two. The questions used in the interviews were inspired by the survey of the quantitative study as well as the extensive research that was conducted on the topic. Yet, I worried about how I would merge both findings so they would compliment each other. Though the initial phases of the thematic analysis were chaotic (familiarizing myself with the data set, coding, producing thematic maps), I truly enjoyed the analysis process as I observed the emergence of multiple themes and sub-themes.

I viewed the overall approach of my study as a first step to begin understanding the existing beliefs within the community, and the aim was to use the the outcome of my research to inform future studies. While I was faced with many challenges, the positive aspects of the research process encouraged me to look

forward to conducting future research that would build upon my current study. The explorative nature of this research was a crucial step to initiate my future endeavors to research this area of interest.

The data collection phase of both studies occurred within the same time frame. Because I was conducting the study in Kuwait, I was faced with the challenge of returning home following the completion of my academic semester in time to conduct the study before students went on summer vacation. My concerns revolved around missing the opportunity and being obliged to postpone the project to the following summer. However, I was fortunate enough to work with a team at the high school that was highly cooperative and supportive which allowed me to collect all the necessary data within the constricted time frame. A great amount of preparation went into the planning and arrangement of the intervention phase. I felt overwhelmed and at times I was nervous about presenting the talks and wondered how the students would react and respond to the study. Nonetheless, the excitement I experienced around educating the youth provided me with the confidence and reassurance I needed.

I was conscious of my passion towards the research project and through a reflexive process attempted to ensure that my own expectations and assumptions did not impact the procedure. Regardless, in qualitative research the researchers' influence on the process is recognized (Higginbottom & Serrant-Green, 2005) and since I was an active participant in the quantitative study as well, I reflected upon

those considerations throughout the procedure. Moreover, due to the similar backgrounds shared between myself and the participants it was essential to consider ethical and methodological dilemmas in terms of my attempt to contain my own biases (Gair, 2012). In addition, I wondered whether those similarities led participants to identify with me and possibly endorse social desirability bias where students answered questions based on public expectations and the desire to please the researcher (Grimm, 2010). While similarities between researcher and participants may cause difficulties and challenges, it is also crucial to recognize the opportunities that may emerge under such circumstances (Serrant-Green, 2002). Following the talks, several students felt comfortable enough to approach me and request further information on different mental illnesses and services that provide therapeutic support.

In regards to my clinical practice, this research has enabled me to consider the ways in which stigma impacts my clients. This study aimed to investigate the existence and effects of public stigma. Yet, previous studies recognized self-stigma as a harmful outcome of public stigma (Yanos et al., 2015). Hence, counselling psychologists should place an emphasis on exploring client's experiences of public and self-stigma. This would allow the therapist to gain an understanding of the client's coping mechanisms, the way they react to public stigma and shame, and investigate whether they avoid seeking professional and personal support out of fear of being judged. This will enable psychologists to provide clients with the necessary support and inform future interventions. In addition, this may prompt mental health

professionals to increase psychoeducation programs to educate family members and encourage more accepting behaviors through the process of gaining knowledge.

The challenges, the obstacles, the ups and downs of the research process have undeniably allowed me to discover a number of new features around my personal and professional identity. More importantly, it has enabled me to embrace and combine elements such as self-discipline, creativity, passion, flexibility, empathy and independence in order to make valuable contributions to the field of psychology both as a practitioner and a researcher. Although the process consumed a high level of my time and energy, the outcome of the overall experience has unquestionably been one of the most treasured experiences of my life. I am filled with motivation to continuously develop personally and professionally and implement all that I have learned towards future research and practice. The most important tool that I have gained throughout the experience is the instrument of reflection. The reflective process encourages the continuous journey of self-development and allows researchers and practitioners to maintain their motivation and constantly seek new knowledge. But most importantly, it enabled us to remain curious. As long as curiosity is present, stagnation is unlikely to occur.

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Appendices

Appendix A – Ethics Approval Code 2 – Approved Subject to Conditions

Date 23rd November 2016

Sara Al Sayed (Niall Galbraith)
University of Wolverhampton
FEHW

Dear Sara Al Sayed (Niall Galbraith)

Re: The Impact of an Educational Talk on Adolescents' Attitudes Towards Mental Health submitted to The Faculty of Education, Health and Wellbeing Ethics Panel (Health Professions, Psychology, Social Work & Social Care)

The Faculty Ethics Panel (Health Professions, Psychology, Social Work & Social Care) has considered and reviewed your submission**.**

On review your Research Proposal was passed and given approval **Code 2 – Approved Subject to Conditions.** The conditions for Approval are below.

B. Resubmit for Chair's action. You will need to revise and re-submit your ethics application form to the Chair for re-review prior to full approval being granted. The revisions and changes required are listed below.

Required Changes:

- Consider removing the subscales titles in the questionnaires as this may influence how respondents answer.
- Please amend the Community Attitudes Towards Mental Illness Questionnaire Question 6 – replace "I" with "Is".
- Please clarify how you intend to randomly assign the group.
- Methodological point – There is clearly and 10 point CAMI and a 40 point CAMI. Could you please clarify if the participants are going to do the 10 point CAMI before the talk or after the talk, therefore ensuring the presentation covers the constructs within the CAMI.
- The demographics and role of the control group (Group 2) requires greater clarification.

In your resubmission, please ensure you highlight any changes you have made to the ethics approval form. Also you **must provide a covering letter**, which should be the first page of the resubmitted ethical approval document. You should identify the code allocated, list the concerns raised by the ethics Panel and, following each point, give your responses to these concerns describing how you have changed your application. In the title of the resubmission email please state that this is a resubmission and indicate the code that the previous application received.

Students, please contact your supervisor for assistance with making amendments to your proposal. Supervisors, you must read through and check the revised applications prior to resubmitting them to fehwethics@wlv.ac.uk, r.darby@wlv.ac.uk & h.paniagua@wlv.ac.uk.

Please endeavour to re-submit within 2 months of receiving this letter or you submission may need to be reviewed as a new submission**.**

Best wishes in the future.

Yours sincerely

H Paniagua
Dr. H. Paniagua PhD, MSc, BSc (Hons) Cert. Ed. RN RM
Chair – Ethics Panel

Richard Darby
Dr Richard Darby PhD, BSc
Chair – Ethics Panel

Appendix B – Ethics Resubmission

Sara Al Sayed – Student ID: 1431396
University of Wolverhampton
February 12th 2017

Code 2: Ethics Form Approved Subject to Conditions

Project Title:
The Impact of an Educational Talk on Adolescents' Attitudes Towards Mental Health

Dear Dr. Paniagua and Dr. Darby,

Thank you for taking the time to assess my ethics application. I have made the necessary amendments for your kind attention and have highlighted the changes on the ethics application form.

Required Changes:

1. **Consider removing the subscales titles in the questionnaire as this may influence how respondents answer.**
   The subscales titles have been removed from the questionnaire in order to avoid influencing how respondents answer.

2. **Please amend the Community Attitudes Towards the Mentally Ill Questionnaire Question 6 – replace "I" with "Is".**
   "I" has been replaced by "Is" in question 6 of the CAMI questionnaire. However, my supervisor and I have decided to use a shorter version of the questionnaire which would include only 2 of the 4 subscales available (20 questions in total instead of 40 questions). Question 6 of the original format will not be included. Refer to Condition 4 for more information.

3. **Please clarify how you intend to randomly assign the group.**
   During my meeting with the counselor of the American International School of Kuwait on January 10th 2017, he mentioned that high school students that will be taking part in the study are those who would have "Free Block" on the date the research will be conducted. Free Block is an hour allocated to students for independent study time depending on their class schedules (they have no classes during that hour therefore I will not be interrupting their class timetables). This will be a mix of students from ages 14 to 18 and is the most practical way for the school to manage this allocation.

4. **Methodological point – There is clearly a 10 point CAMI and a 40 point CAMI. Could you please clarify if the participants are going to do the 10 point CAMI before the talk or after the talk, therefore ensuring the presentation covers the constructs within the CAMI.**

   After an extensive search with my supervisor we were unable to find a 10-point CAMI scale, however, each of the 4 subscales in the questionnaire has its' own validity. Therefore, after a revision of the questionnaire, my supervisor and I thought it would be best to do a 20 point CAMI and include only 2 subscales: Benevolence and Social Restrictiveness.

   Each subscale contains 10 questions, therefore students will be completing a total of 20 questions before the talk and once again after the talk (in order to assess effects of the talks on the student's attitudes). The two subscales that were chosen focus on:

   - Benevolence subscale: the level of empathy one has towards someone diagnosed with a mental health disorder
   - Social Restrictiveness subscale: views one might have towards mental health including someone diagnosed with a mental health disorder in his/her community and any given social situation.

   The questions in the chosen subscales fit best with the objectives of the research and the content of the talk that will be given to group 1 (myths and facts on mental health). The use of particular subscales is acceptable in the context of each subscale having its' own norms and standardization process and thus one is able to use them as stand alone scales depending on the research focus. (Refer to CAMI questionnaire "Scoring" part in Appendix). Moreover, students will not have time to complete the full 40 point CAMI twice in an hour, thus, our decision to shorten it and only include 20 of the 40 questions.

5. **The demographics and role of the control group (Group 2) requires greater clarification.**

   Group 2 do not differ systematically in demographics from Group 1 and they are used as a comparison group. Group 2 will receive the talk on career paths in psychology and not the talk on myths/facts of mental health.

   There will be no specific demographic background for either group other than their age: students in both Group 1 and Group 2 will have to be in high school (ages 14 to 18).

   However, all students participating will be asked to fill out a background information sheet which will contain information such as: ethnicity, age, gender, etc. (refer to Participant Background Form). Because the school is heterogeneous in terms of nationality, ethnicity and religious backgrounds it is important for me to collect such information.

   Group 2 (control group) will be given a general talk on career opportunities and educational paths they could take within the field of psychology without touching on subjects regarding mental illness.

   The objective is to explore whether both talks have the same effect or no effect at all in changing adolescents' attitudes towards mental health.

Appendix C – Ethics Approval Code 1 – Pass

22nd February 2017

Sara Al Sayed (Dr Niall Galbraith & Dr Nick Banks)
University of Wolverhampton
FEHW

Dear Sara Al Sayed (Dr Niall Galbraith & Dr Nick Banks)

Re: The Impact of an Educational Talk on Adolescents' Attitudes Towards Mental Health submitted to the Chair Faculty of Education, Health and Wellbeing Ethics Sub-panel (Health Professions, Psychology, Social Care & Social Work)

Upon review by the Chair of the Ethics Sub-panel on 17th February 2017 your Resubmitted Research Proposal was passed and given full approval (**Code 1 - Pass**). You are free to continue with your study. We would like to wish you every success with the project.

Yours sincerely

H Paniagua
Dr. H. Paniagua PhD, MSc, BSc (Hons) Cert. Ed. RN RM
Chair – School Ethics Committee

Richard Darby
Dr Richard Darby PhD, BSc
Chair – Ethics Panel

Appendix D – Letter to the American International School of Kuwait

American International School of Kuwait
Uhud St., Meidan Hawalli, Kuwait.

To whom it may concern,

As part of my Doctorate in Counselling Psychology course at the University of Wolverhampton, I am proposing to conduct a research project at the American International School of Kuwait.

If you agree to take part this will involve two separate talks to two different groups of high school students. The first group will receive an educational talk on the different myths and facts surrounding the field of mental health and people suffering from mental health difficulties. The second group will be receiving an informative talk on the different educational and professional paths one can take within the field of psychology. Both groups will be asked to fill out the Community Attitudes Towards the Mentally Ill questionnaire.

The potential benefits of this research include the educational nature of the talks which will enrich the students' knowledge on the topic and equip them with the proper awareness. Furthermore, it will allow them to explore the possible opportunities and build on their existing knowledge.

This research has been cleared by the ethics committee of the University of Wolverhampton. I am therefore writing to seek your permission to conduct this study at the American International School of Kuwait with the students and enclose a copy of the research protocol for your information.

I look forward to hearing from you.
Yours Sincerely,
Sara Al Sayed
Email: s.alsayed@wlv.ac.uk

Appendix E – Letter to Participants – Quantitative Study

LETTER TO PARTICIPANTS

Dear Student,

I am writing to invite you to participate in a research project which I am conducting as part of a Doctorate course in Counselling Psychology I am taking at the University of Wolverhampton. I have enclosed an information sheet which contains aims of the study and what taking part will involve.

If you are willing to take part in the informative talk about mental health and psychology and fill out the questionnaire it would take approximately 50 minutes all together.
All questionnaires will be anonymized and confidential and will be destroyed after the completion of the study. The study will take place at the American International School of Kuwait and all findings of the research will remain anonymized.

If you decide to take part in the study you will be asked to read the information sheet and sign the consent form. If you decide not to take part in the study, any decision you make will be respected.

Yours Sincerely,

Sara Al Sayed

Appendix F – Letter to Participants – Qualitative Study

LETTER TO PARTICIPANTS

Dear Student,

I am writing to invite you to participate in a research project which I am conducting as part of a Doctorate course in Counselling Psychology I am taking at the University of Wolverhampton. I have enclosed an information sheet which contains aims of the study and what taking part will involve.

If you are willing to be interviewed, the interview will last approximately 30 minutes. Anything you say during the interview will remain confidential and all reports will be anonymized and destroyed after the completion of the study.
The study will take place at a time and location that is convenient to yourself and all findings reported in the research will remain anonymized so that you cannot be identified.

If you decide to take part in the study you will be asked to read the information sheet and sign the consent form. If you decide not to take part in the study, any decision you make will be respected.

Yours Sincerely,

Sara Al Sayed

Appendix G – Participant Information Sheet – Quantitative Study

PARTICIPANT INFORMATION SHEET

Researcher
Sara Al Sayed
Full-time student: Doctorate in Counselling Psychology
University of Wolverhampton

This research is carried out as part of the Doctorate program of studies undertaken at the University of Wolverhampton

Purpose of the study:
There is little evidence on the benefits of educating the youth on psychology and mental health issues. The purpose of this study is to examine the outcome of a brief educational talk on different aspects of mental health and the field of psychology. This study will help us understand better how students perceive psychology and the issues related to mental health.

Why were you chosen:
The study aims to focus on the viewpoints of adolescents between the ages of 14 and 18, thus the decision to target high school students. Any student in grade 9 to grade 12 is welcome to take part in the study.

Do I have to take part?
It is completely up to you to decide whether you would like to take part in the study. If you decide to participate then you will be given this information sheet to keep along with a consent form that you will be asked to sign. You are free to withdraw from the study at any point until the surveys are handed in as I will not be able to identify your data.

What will happen if I decide to take part?
You will be asked to attend an informative talk about psychology and mental health that will last 30 minutes along with a 10minute Q&A session which will allow you to ask any question regarding the topic. You will also be asked to fill in a questionnaire.

Benefits & Risks of taking part:
By taking part you are exposing yourself to a beneficial learning experience. Moreover, you are contributing to the development of research and understanding within the field of psychology.

There are no risks to you or others outside those you would experience in everyday life. However, the topic may stir up emotions related to personal experiences in dealing with mental health difficulties. If at any point you require support please do not hesitate to let us know and if you are unable to continue your participation in the study, any decision you make will be respected.

Confidentiality:
All reports will be kept confidential and anonymous. Data will be stored on a password protected computer in a locked office and questionnaires and interviews will be identified with numbers. You will not be identifiable in any report and only the researcher will have access to the information.

What will happen at the end of the research study?
The results of the study will be presented in the researcher's thesis for the Doctorate program of Counselling Psychology at the University of Wolverhampton. Any students interested in reading the results of the research could directly contact the researcher at s.alsayed@wlv.ac.uk

Problems or concerns:
If you have any problems or concerns, feel free to ask the researcher to assist you with these or any other school personnel.

Contact Information:

Researcher: Sara Al Sayed	email: s.alsayed@wlv.ac.uk
Primary Supervisor: Niall Galbraith	email: n.galbraith@wlv.ac.uk

Thank you very much,

Sara Al Sayed.

Appendix H – Participant Information Sheet – Qualitative Study

PARTICIPANT INFORMATION SHEET

Researcher
Sara Al Sayed
Full-time student: Doctorate in Counselling Psychology
University of Wolverhampton

This research is carried out as part of the Doctorate program of studies undertaken at the University of Wolverhampton

Purpose of the study:
There is little evidence on the benefits of educating the youth on psychology and mental health issues. The purpose of this study is to examine the outcome of a brief educational talk on different aspects of mental health and the field of psychology. This study will help us understand better how students perceive psychology and the issues related to mental health.

Why were you chosen:
The study aims to focus on the viewpoints of adolescents between the ages of 14 and 18, thus the decision to target high school students. Any student in grade 9 to grade 12 is welcome to take part in the study.

Do I have to take part?
It is completely up to you to decide whether you would like to take part in the study. If you decide to participate then you will be given this information sheet to keep along with a consent form that you will be asked to sign. You are free to withdraw from the study at any point.

What will happen if I decide to take part?
You will be asked to take part in an interview to answer 6 questions about mental health and the field of psychology.

Benefits & Risks of taking part:
By taking part in this study you are contributing to the development of research and understanding within the field of psychology.
There are no risks to you or others outside those you would experience in everyday life. However, the topic may stir up emotions related to personal experiences in dealing with mental health difficulties. If at any point you require support please do not hesitate to let us

know and if you are unable to continue your participation in the study, any decision you make will be respected.

Confidentiality:
All reports will be kept confidential and anonymous. Data will be stored on a password protected computer in a locked office and questionnaires and interviews will be identified with numbers. You will not be identifiable in any report and only the researcher will have access to the information.

What will happen at the end of the research study?
The results of the study will be presented in the researcher's thesis for the Doctorate program of Counselling Psychology at the University of Wolverhampton. Any students interested in reading the results of the research could directly contact the researcher at s.alsayed@wlv.ac.uk

Problems or concerns:
If you have any problems or concerns, feel free to ask the researcher to assist you with these or any other school personnel.

Contact Information:

Researcher: Sara Al Sayed	email: s.alsayed@wlv.ac.uk
Primary Supervisor: Niall Galbraith	email: n.galbraith@wlv.ac.uk

Thank you very much,

Sara Al Sayed.

Appendix I – Participant Consent Form – Quantitative Study

CONSENT FORM

Researcher:
Sara Al Sayed
Professional Doctorate in Counselling Psychology
University of Wolverhampton

1. I confirm that I have read and understand the information sheet dated January 15 2017 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time/up until commencement of data analysis, without giving any reason. ☐

3. I understand that my data will be stored securely and confidentially ☐

and that I will not be identifiable in any report or publication.

4. I understand that the researcher may wish to publish this study and any results found, for which I give my permission. ☐

5. I agree for the data on my questionnaire to be used for the purpose of this study. ☐

6. I agree to take part in the above study. ☐

……..	……..	……
Name	Date	Signature
…….	…….	……
Researcher	Date	Signature

Appendix J – Participant Consent Form – Qualitative Study

CONSENT FORM

Researcher:
Sara Al Sayed
Professional Doctorate in Counselling Psychology
University of Wolverhampton

7. I confirm that I have read and understand the information sheet dated January 15 2017 for the above study and have had the opportunity to ask questions. ☐

8. I understand that my participation is voluntary and that I am free to withdraw at any time/up until commencement of data analysis, without giving any reason. ☐

9. I understand that my data will be stored securely and confidentially and that I will not be identifiable in any report or publication. ☐

10. I understand that the researcher may wish to publish this study and any results found, for which I give my permission. ☐

11. I agree for my interview to be tape recorded and for the data to be used for the purpose of this study. ☐

12. I agree to take part in the above study. ☐

……..	……..	……
Name	Date	Signature
…….	…….	……
Researcher	Date	Signature

Appendix K – Debrief Sheet

DEBRIEF SHEET

Researcher
Sara Al Sayed
Full-time student: Doctorate in Counselling Psychology
University of Wolverhampton

This study was an exploration of the viewpoints of adolescents between the ages of 14years old and 18years old on mental health issues.
Many people suffering from mental health difficulties face discrimination, which in effect reduces their desire to seek help and makes their day to day lives harder.
The purpose of this study was to examine whether a brief educational talk on mental health would be sufficient enough to have an impact on student's beliefs. The aim is to be able to reduce the stigma by educating the youth and encourage more accepting behaviors.
Attitudes towards mental health were measured using the "Community Attitudes towards the Mentally Ill" scale.
Students were divided into two groups:
1) those who received the informative talk about mental health disorders
2) those who received a general talk about the professional and educational paths on can take within the field of psychology.
Both groups were asked to fill out the survey before and after the talk to allow the researcher to compare: 1) differences in responses between both groups
2) differences in responses before and after the talk

We anticipate that educating the younger generations will have an effect on their perspectives towards mental health issues and will aid in reducing the discrimination and promote more accepting beliefs and behaviors.

Following the study, if you feel the necessity to seek support, you can do so at the following locations:

- American International School Counselling Service: Mr. Mark Ray
- Soor Center for Professional Therapy & Assessment: 22901677
- Fawzia Sultan Rehabilitation Institute: 25720338

If you have any questions regarding the study, please contact:

Researcher: Sara Al Sayed
Email: s.alsayed@wlv.ac.uk

Research Supervisor: Dr. Niall Galbraith
Email: n.galbraith@wlv.ac.uk

THANK YOU AGAIN FOR YOUR PARTICIPATION AND COOPERATION.

Appendix L – Participant Background Form

What is your age?

Age: _____

What grade are you in?

Grade: _____

What is your gender:

☐ Male ☐ Female

Which of the following best describes your ethnic background?

☐ African American or Black

☐ Arab

☐ White/Caucasian

☐ Other. Please Specify: _____

☐ Hispanic

☐ Asian (Indian, Pakistani etc.)

☐ Asian (Chinese, Japanese etc.)

Have you ever taken a Psychology course, or any related course?

☐ Yes ☐ No

If yes, please specify the name of the course: _____

Do you know or have you ever met a person suffering from mental health problems?

☐ Yes ☐ No

Appendix M – Community Attitudes Towards the Mentally Ill Questionnaire

Community Attitudes Toward Mentally Ill.

(Taylor & Dear, 1981)

5 point Likert Scale

1) **The mentally ill have for too long been the subject of ridicule.**

1)Strongly Disagree 2)Disagree 3)Neutral 4)Agree 5)Strongly Agree

2) **More tax money should be spent on the care and treatment of the mentally ill.**

1)Strongly Disagree 2)Disagree 3)Neutral 4)Agree 5)Strongly Agree

3) **We need to adopt a far more tolerant attitude toward the mentally ill in our society.**

1)Strongly Disagree 2)Disagree 3)Neutral 4)Agree 5)Strongly Agree

4) **Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for.**

1)Strongly Disagree 2)Disagree 3)Neutral 4)Agree 5)Strongly Agree

5) **We have a responsibility to provide the best possible care for the mentally ill.**

1)Strongly Disagree 2)Disagree 3)Neutral 4)Agree 5)Strongly Agree

6) **The mentally ill don't deserve our sympathy.**

1)Strongly Disagree 2)Disagree 3)Neutral 4)Agree 5)Strongly Agree

7) The mentally ill are a burden on society.

1)Strongly Disagree 2)Disagree 3)Neutral 4)Agree 5)Strongly Agree

8) Increased spending on mental health services is a waste of tax dollars

1)Strongly Disagree 2)Disagree 3)Neutral 4)Agree 5)Strongly Agree

9) There are sufficient existing services for the mentally ill.

1)Strongly Disagree 2)Disagree 3)Neutral 4)Agree 5)Strongly Agree

10) It is best to avoid anyone who has mental problems.

1)Strongly Disagree 2)Disagree 3)Neutral 4)Agree 5)Strongly Agree

11) The mentally ill should not be given any responsibility.

1)Strongly Disagree 2)Disagree 3)Neutral 4)Agree 5)Strongly Agree

12) The mentally ill should be isolated from the rest of the community.

1)Strongly Disagree 2)Disagree 3)Neutral 4)Agree 5)Strongly Agree

13) A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered.

1)Strongly Disagree 2)Disagree 3)Neutral 4)Agree 5)Strongly Agree

14) I would not want to live next door to someone who has been mentally ill.

1)Strongly Disagree 2)Disagree 3)Neutral 4)Agree 5)Strongly Agree

15) Anyone with a history of mental problems should be excluded from taking public office.

1)Strongly Disagree 2)Disagree 3)Neutral 4)Agree 5)Strongly Agree

16) The mentally ill should not be denied their individual rights.

1)Strongly Disagree 2)Disagree 3)Neutral 4)Agree 5)Strongly Agree

17) Mental patients should be encouraged to assume the responsibilities of normal life.

1)Strongly Disagree 2)Disagree 3)Neutral 4)Agree 5)Strongly Agree

18) No one has the right to exclude the mentally ill from their neighborhood.

1)Strongly Disagree 2)Disagree 3)Neutral 4)Agree 5)Strongly Agree

19) The mentally ill are far less of a danger than most people suppose.

1)Strongly Disagree 2)Disagree 3)Neutral 4)Agree 5)Strongly Agree

20) Most women who were once patients in a mental hospital can be trusted as babysitters.

1)Strongly Disagree 2)Disagree 3)Neutral 4)Agree 5)Strongly Agree

Appendix N – Interview Questions

INTERVIEW QUESTIONS

1. How do you think mental health illness could be explained? What causes the illness?

2. What is your personal experience in dealing with mental health disorders/difficulties? (own experience, family member, friend, acquaintance)

3. Would you marry or date someone that was diagnosed with a mental health disorder/difficulty? If yes, why? If not, why?

4. Do you believe people with mental health disorders/difficulties are of greater risk to other people?
   If yes, can you give me an example?
   If not, what makes them just like everyone else?

5. If you found out a family member, friend or partner was diagnosed with a mental health disorder how would you feel?
   What kind of support would you provide them with?

6. If you were diagnosed with a mental health disorder how do you imagine your life would be? (education, career, relationships).
   Do you think people will treat you fairly?

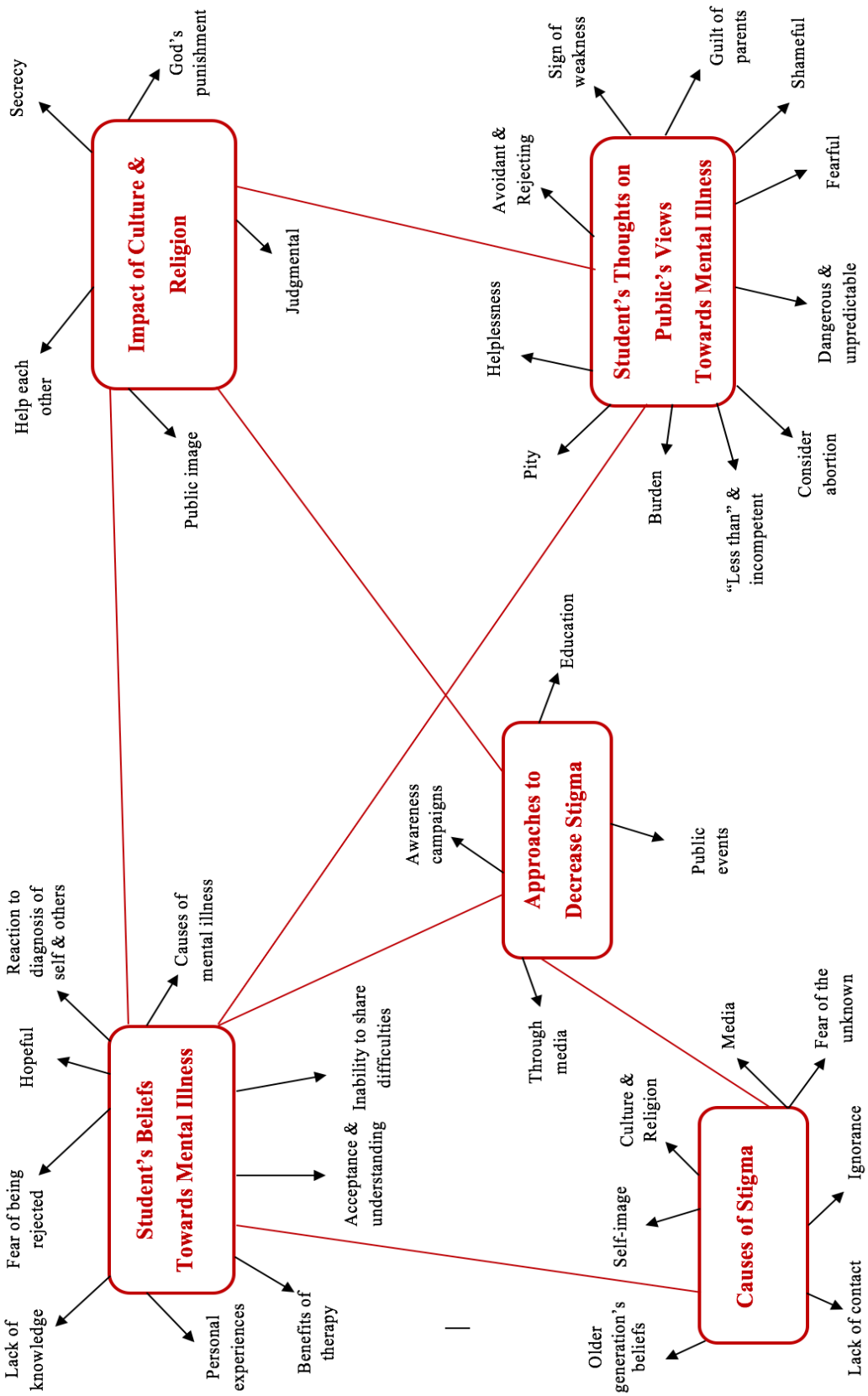
7. Do you believe people with mental health disorders are discriminated against?

8. Why is there stigma towards mental health? Culture? Religion?

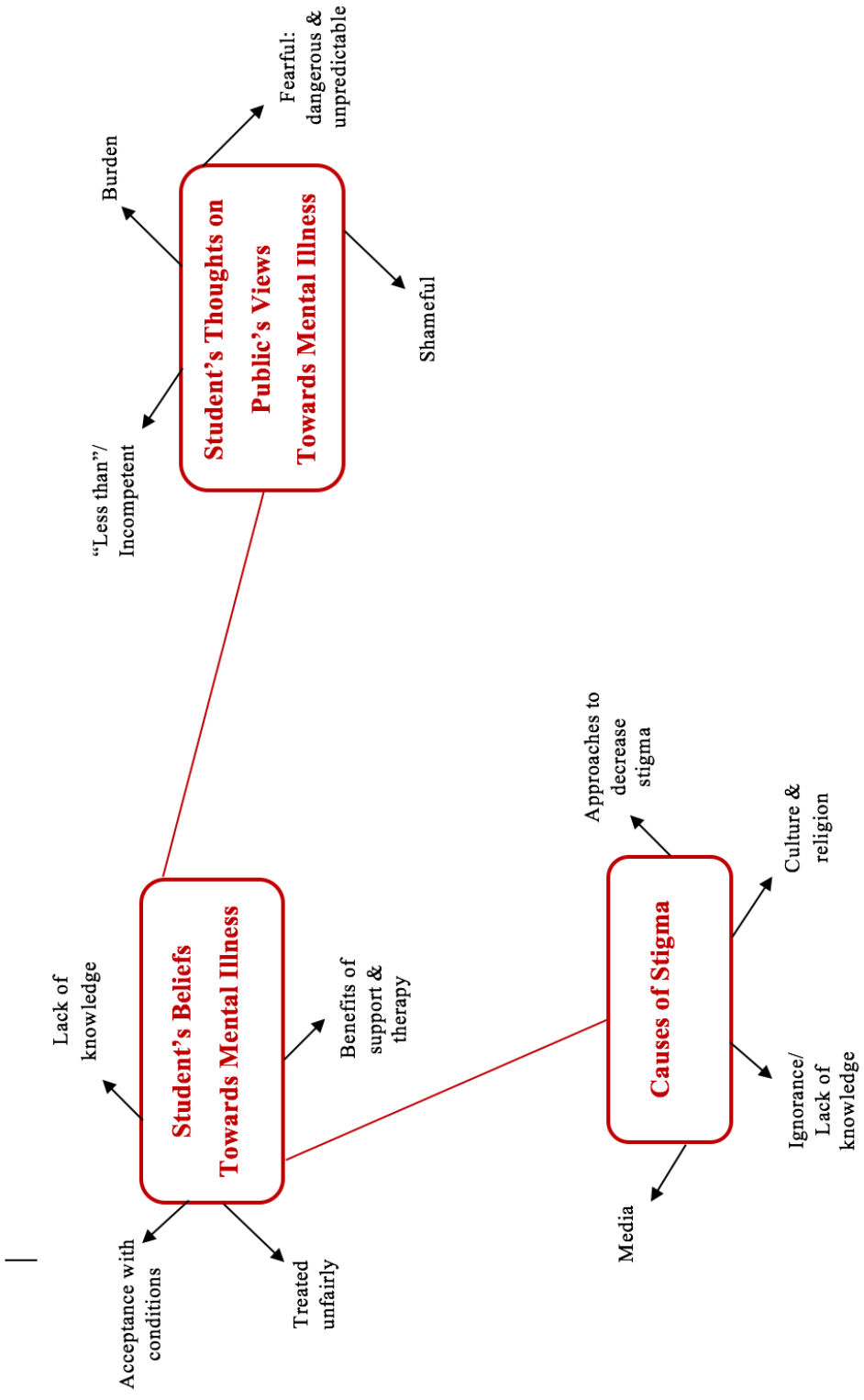
9. How could the stigma towards mental health be reduced?

10. You are the CEO of a company and a qualified applicant comes in to interview for the position of Marketing Director. They meet all the position requirements however they tell you they are diagnosed with Schizophrenia and are stable on medication, would you hire them?
    If yes, why?
    If not, why?

Appendix O – Thematic Map Initial Themes



Appendix P – Thematic Map Refined Themes



Appendix Q – SPSS Outputs Benevolence Subscale

Within-Subjects Factors

Measure: MEASURE_1

Before_after	Dependent Variable
1	Benevolence_before
2	Benevolence_after

Between-Subjects Factors

		Value Label	N
Group	1.00	Edu	52
	2.00	Myth-Fact	53

Multivariate Tests[a]

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
Before_after	Pillai's Trace	.202	26.045[b]	1.000	103.000	.000	.202
	Wilks' Lambda	.798	26.045[b]	1.000	103.000	.000	.202
	Hotelling's Trace	.253	26.045[b]	1.000	103.000	.000	.202
	Roy's Largest Root	.253	26.045[b]	1.000	103.000	.000	.202
Before_after * Group	Pillai's Trace	.020	2.058[b]	1.000	103.000	.154	.020
	Wilks' Lambda	.980	2.058[b]	1.000	103.000	.154	.020
	Hotelling's Trace	.020	2.058[b]	1.000	103.000	.154	.020
	Roy's Largest Root	.020	2.058[b]	1.000	103.000	.154	.020

a. Design: Intercept + Group
Within Subjects Design: Before_after

b. Exact statistic

Mauchly's Test of Sphericity[a]

Measure: MEASURE_1

Within Subjects Effect	Mauchly's W	Approx. Chi-Square	df	Sig.	Epsilon[b]		
					Greenhouse-Geisser	Huynh-Feldt	Lower-bound
Before_after	1.000	.000	0	.	1.000	1.000	1.000

Tests the null hypothesis that the error covariance matrix of the orthonormalized transformed dependent variables is proportional to an identity matrix.

a. Design: Intercept + Group
Within Subjects Design: Before_after

b. May be used to adjust the degrees of freedom for the averaged tests of significance. Corrected tests are displayed in the Tests of Within-Subjects Effects table.

Tests of Within-Subjects Effects

Measure: MEASURE_1

Source		Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Before_after	Sphericity Assumed	360.776	1	360.776	26.045	.000	.202
	Greenhouse-Geisser	360.776	1.000	360.776	26.045	.000	.202
	Huynh-Feldt	360.776	1.000	360.776	26.045	.000	.202
	Lower-bound	360.776	1.000	360.776	26.045	.000	.202
Before_after * Group	Sphericity Assumed	28.509	1	28.509	2.058	.154	.020
	Greenhouse-Geisser	28.509	1.000	28.509	2.058	.154	.020
	Huynh-Feldt	28.509	1.000	28.509	2.058	.154	.020
	Lower-bound	28.509	1.000	28.509	2.058	.154	.020
Error(Before_after)	Sphericity Assumed	1426.748	103	13.852			
	Greenhouse-Geisser	1426.748	103.000	13.852			
	Huynh-Feldt	1426.748	103.000	13.852			
	Lower-bound	1426.748	103.000	13.852			

Tests of Within-Subjects Contrasts

Measure: MEASURE_1

Source	Before_after	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Before_after	Linear	360.776	1	360.776	26.045	.000	.202
Before_after * Group	Linear	28.509	1	28.509	2.058	.154	.020
Error(Before_after)	Linear	1426.748	103	13.852			

Tests of Between-Subjects Effects

Measure: MEASURE_1

Transformed Variable: Average

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Intercept	329575.855	1	329575.855	9936.246	.000	.990
Group	280.616	1	280.616	8.460	.004	.076
Error	3416.412	103	33.169			

Estimated Marginal Means

1. Group

Measure: MEASURE_1

Group	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
Edu	38.462	.565	37.342	39.582
Myth-Fact	40.774	.559	39.664	41.883

2. Before_after

Measure: MEASURE_1

Before_after	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
1	38.307	.518	37.279	39.334
2	40.928	.424	40.088	41.768

3. Group * Before_after

Measure: MEASURE_1

Group	Before_after	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Edu	1	37.519	.736	36.059	38.979
	2	39.404	.602	38.210	40.597
Myth-Fact	1	39.094	.729	37.648	40.541
	2	42.453	.596	41.271	43.635

Appendix R – SPSS Outputs Social Restrictiveness Subscale

Within-Subjects Factors

Measure: MEASURE_1

Before_after	Dependent Variable
1	SocRestr_before
2	SocRestr_after

Between-Subjects Factors

		Value Label	N
Group	1.00	Edu	52
	2.00	Myth-Fact	53

Multivariate Tests[a]

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
Before_after	Pillai's Trace	.219	28.934[b]	1.000	103.000	.000	.219
	Wilks' Lambda	.781	28.934[b]	1.000	103.000	.000	.219
	Hotelling's Trace	.281	28.934[b]	1.000	103.000	.000	.219
	Roy's Largest Root	.281	28.934[b]	1.000	103.000	.000	.219
Before_after * Group	Pillai's Trace	.139	16.646[b]	1.000	103.000	.000	.139
	Wilks' Lambda	.861	16.646[b]	1.000	103.000	.000	.139
	Hotelling's Trace	.162	16.646[b]	1.000	103.000	.000	.139
	Roy's Largest Root	.162	16.646[b]	1.000	103.000	.000	.139

a. Design: Intercept + Group
Within Subjects Design: Before_after

b. Exact statistic

Mauchly's Test of Sphericity[a]

Measure: MEASURE_1

Within Subjects Effect	Mauchly's W	Approx. Chi-Square	df	Sig.	Epsilon[b]		
					Greenhouse-Geisser	Huynh-Feldt	Lower-bound
Before_after	1.000	.000	0	.	1.000	1.000	1.000

Tests the null hypothesis that the error covariance matrix of the orthonormalized transformed dependent variables is proportional to an identity matrix.

a. Design: Intercept + Group
Within Subjects Design: Before_after

b. May be used to adjust the degrees of freedom for the averaged tests of significance. Corrected tests are displayed in the Tests of Within-Subjects Effects table.

Tests of Within-Subjects Effects

Measure: MEASURE_1

Source		Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Before_after	Sphericity Assumed	480.606	1	480.606	28.934	.000	.219
	Greenhouse-Geisser	480.606	1.000	480.606	28.934	.000	.219
	Huynh-Feldt	480.606	1.000	480.606	28.934	.000	.219
	Lower-bound	480.606	1.000	480.606	28.934	.000	.219
Before_after * Group	Sphericity Assumed	276.492	1	276.492	16.646	.000	.139
	Greenhouse-Geisser	276.492	1.000	276.492	16.646	.000	.139
	Huynh-Feldt	276.492	1.000	276.492	16.646	.000	.139
	Lower-bound	276.492	1.000	276.492	16.646	.000	.139
Error(Before_after)	Sphericity Assumed	1710.889	103	16.611			
	Greenhouse-Geisser	1710.889	103.000	16.611			
	Huynh-Feldt	1710.889	103.000	16.611			
	Lower-bound	1710.889	103.000	16.611			

Tests of Within-Subjects Contrasts

Measure: MEASURE_1

Source	Before_after	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Before_after	Linear	480.606	1	480.606	28.934	.000	.219
Before_after * Group	Linear	276.492	1	276.492	16.646	.000	.139
Error(Before_after)	Linear	1710.889	103	16.611			

Tests of Between-Subjects Effects

Measure: MEASURE_1

Transformed Variable: Average

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Intercept	98945.067	1	98945.067	3664.633	.000	.973
Group	340.496	1	340.496	12.611	.001	.109
Error	2780.999	103	27.000			

Estimated Marginal Means

1. Group

Measure: MEASURE_1

Group	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
Edu	22.981	.510	21.970	23.991
Myth-Fact	20.434	.505	19.433	21.435

2. Before_after

Measure: MEASURE_1

Before_after	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
1	23.220	.464	22.300	24.140
2	20.194	.447	19.307	21.082

3. Group * Before_after

Measure: MEASURE_1

Group	Before_after	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Edu	1	23.346	.659	22.039	24.654
	2	22.615	.636	21.355	23.876
Myth-Fact	1	23.094	.653	21.799	24.390
	2	17.774	.630	16.525	19.022